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Narratives of Under-Representation: Older Pakistani Women's Accounts of their Health and Social Care Experiences

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A thesis submitted in partial fulfilment of the requirements of the Manchester Metropolitan University for the degree of Doctor of Philosophy

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Abstract: Narratives of Under-Representation; Older Pakistani women's accounts of their health and social care experiences

This research project explores older Pakistani women's narratives of their interactions with health and social care systems. Initially situated in social work practice, the study developed from my experience working in an intermediate care facility. The project was located in a town identified as one of the most deprived in England in 2016, and where 10% of the population self-identified as Pakistani according to 2010 Census data. Rather than remain located in a specific service, the project evolved to take a broader approach; narrative interviews were conducted with eight older Pakistani women. The open question '*please tell me about an encounter you have had with health or social care*' elicited a spectrum of responses. Transcripts were analysed using dialogic performance analysis and each interview was developed into a case study incorporating extracts of the original transcripts. Four themes were then constructed through thematic analysis of the narratives from each case study. The themes expose the intersectional nature of oppression and disadvantage experienced in interactions with health and social care services. This indicates that social class plays a substantial role in whether racial abuse and/or discrimination has an impact on an individual's identity. Social class was also important in generating boundaries of space and place, with increased capital playing a key role in expanding the boundaries of 'safe spaces.' Racism was experienced by all participants and was generalised across numerous different fields, leading in many cases to an expectation of poor care provision. The implications of these findings are two-fold; primarily, those who experience the most intersectional oppression are most likely to have their identity affected by racial abuse and/or discrimination, therefore affecting their future interactions. Additionally, those experiencing significant intersectional disadvantage are less likely to encounter the white population outside of health and social care interactions. It is therefore in these exchanges that the impact on identity is played out, with potential consequences for the health of these individuals.

Secondly, racist behaviour is generalised from one professional to whole professional groups, and from one field to another, contributing to the development of a system of

representation. This indicates that any steps taken to adapt or improve the accessibility of individual services will have limited, localised impact at most. To facilitate more equitable distribution of health and care services, the emphasis needs to be on addressing intersectional oppression and discrimination on a societal level, with a focus on the limiting impact of socio-economic disadvantage and dismantling of oppressive representational systems

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1. Introduction

1.1 Reflecting on the idea

In 2008 I qualified as a social worker and accepted a role on an Adult Duty team in a local authority named the most deprived in England by the Office for National Statistics in 2016 (Office for National Statistics 2016 [online]). The work was varied and challenging but after two years, during a restructure of adult services, I decided to make a change and requested a transfer to a newly formed 'urgent care team'. This team was responsible for supporting people home from short-term hospital stays and providing social work input in the accident and emergency department, including an out-of-hours provision. In addition, we contributed to the multi-disciplinary intermediate care service, which at the time ran from several local authority managed residential sites across the borough. This involved spending several weeks based in the different units, meeting with the short-term residents and their families in order to ensure a smooth transition home, or on to more suitable accommodation.

It was during these periods in intermediate care that I noticed a distinct lack of ethnic diversity amongst the residents. Residential intermediate care is only provided by the NHS as a short-term transitional provision and therefore the turnover of residents was frequent. This meant that in my three years on the team, it is likely that I met and supported hundreds of people, over this time I cannot remember assessing a single Asian resident. The local authority is highly ethnically diverse, with recent census data indicating that approximately 17% of the population self-define as Bangladeshi or Pakistani (Office for National Statistics 2011 [online]). Recognising this inequity between the local population and the intermediate care population, particularly given the evidence of poorer health outcomes and mortality rate for minority ethnic groups (Rees and Wohland 2008), fuelled a desire to explore further.

As an employee of the local authority, my initial focus was the need to improve or adapt our service in order to address this under-representation and ensure an equitable provision for all residents in the borough. Securing a part-time position on the PhD programme allowed me to explore the issue in more depth, but, although it is difficult to admit, my

local authority social work role tied my thinking to an organisational perspective naively rooted in realist philosophy and essentialist assumptions about 'ethnic minorities'. There is much literature that describes the disconnect between theory and practice in social work (Osterling and Austin 2008), and more that locates this division in the differing priorities of practitioners and academics (Secret, Abell and Berlin 2011). Traversing both fields became a challenge to my value base, particularly at a time where budget cuts had begun to have significant and visible effects on services and the people needing them.

Originally, I proposed to recruit participants to interview via the local authority home care and reablement services and through the hospital discharge system, however it soon became clear that this would not be authorised. At the time this was frustrating but ended up being the best possible outcome. Moving into an academic role a year into the project enabled me to challenge my own philosophical position and changed the trajectory towards a social constructionist/critical theorist approach with a focus on intersectionality, feminism and class.

I feel that in the interests of transparency, this shift in direction is important to disclose as it feels deceptive to claim this thesis as feminist from the outset. Holding a strong ethical and value base is important to me as a social worker, and as a social work researcher, and therefore being honest and open is key to any research project I undertake. At times it has been difficult to explain how the shift in focus has impacted on the study, but where there have been challenges, these are outlined.

1.2 Objectives

This research project is underpinned by a social constructionist philosophy and is exploratory in nature but with a clear critical position in relation to the development and maintenance of demographic divisions. As such, the objectives were developed to acknowledge the relevance of existing data, which identifies an under-representation of specific groups within health and social care services but without adopting a reductionist position. By exploring participants' narratives of their interactions with health and social care experiences, I hoped that a picture could be developed to understand the impact that these exchanges had and consider the reasons for differential experiences whilst

identifying consistencies in treatment. Understanding the way that interaction with services in their current form impacts on participants can enable the development of improvement strategies.

The following four objectives were developed, to give the project a clear focus, but with the understanding that these objectives were flexible, due to the exploratory nature of the study.

1. Explore Pakistani older women's experiences of health and social care in the UK
2. Explore the relationship between Pakistani older women's experiences and their under-representation in health and social care services
3. Explore the impact that these experiences have on Pakistani older women's identities
4. Contribute to improving support in a meaningful way by providing a platform for Pakistani older women's narratives to be heard

When developing the objectives, I naively assumed that I would hear a combination of positive and negative narratives about both health and social care interactions. I expected that an analysis of these would leave me with 'do's' and 'don'ts' to inform service development. Further exploration of literature, in combination with the analysis method drew me to very different conclusions.

1.3 Terms and definitions

This study, like any other research project, uses terminology specific to the area of focus. When exploring disadvantage, especially that which is associated with systematic discrimination against those with protected characteristics, it is important to ensure clarity of terms. As described in chapter four of this thesis, language does not exist in a vacuum, and words 'carry history on their back' (Bakhtin 1981 cited in Riessman 2008:107), often used as a means of oppression and humiliation. Despite the fact that 'there is little in this lexicon of terms that is not contested' (Aspinall 2002:804), it is important to attempt consistency of usage within the same publication, to avoid confusion.

Throughout this thesis there is frequent reference to ethnicity, predominantly when discussing the participants' shared country of origin. This section provides a rationale for my word choice throughout the thesis.

- 'Race'

Malik (1996) states that 'in popular language, 'race' is usually synonymous with 'colour'. We casually speak of Africans (or Afro-Caribbean) as one race, Asians as another, Europeans or 'whites' as a third. Virtually everyone can distinguish between the physical characteristics of the major racial groups [...]. This universal ability to distinguish between different human groups has given credence to the idea that races possess an objective reality' (1996:2). The author continues to explain that this assumption of an objectively real division between races is consolidated in the use of 'race' in legal and policy documents throughout the world. This reification of socially constructed groupings is heavily contested by Malik (1996) as divisive and without evidence or agreed definition.

Given the negative and divisive connotations of the term, I have endeavoured to use 'race' within this thesis only when using a direct quote from a participant, or from a published document where the term has been used. Where 'race' is used to describe findings or points from published work, but without use of a direct quote, quotation marks are used around the word, to indicate its contested nature.

- Ethnicity

Despite Malik's assertion that ethnicity also has no recognised and agreed definition, he acknowledges that the general understanding is that the term recognises the subjective and constructed nature of divisions based on different characteristics. Ethnicity recognises that in order to be an 'ethnic group', members must perceive themselves to be in it, and the shared characteristics include more than just skin colour or physical appearance. Giddens describes 'members of ethnic groups see themselves as culturally distinct from other groupings in society and are seen by those others to be so' (1996:175). Examples of characteristics used to distinguish ethnic groups include language, history and religion.

Ethnicity is used within this thesis, as despite the lack of definition, and the persistent potential to essentialise this term, it feels like it carries less 'history on its back' (Bakhtin

1981). Furthermore, ethnicity fits more clearly with the theoretical underpinning of this thesis; primarily, the involvement of both members and non-members in developing an understanding of the group's identity fits with Jenkins' (2014) definition of a group opposed to a category. In addition, the learned nature of all characteristics, rather than a pre-existing realist category to be born into, fits with the philosophy of social construction.

- Ethnic minority or minority ethnic?

Ethnic minority is a contested term, with some considering 'minority' to have connotations of reduced importance rather than as a reference to its numerical significance. Some propose the alternative 'minoritized' to highlight the conscious and political nature of disadvantage experience by those defined within some ethnic groups (Aspinall 2002). Despite contention, throughout this report, minority ethnic is the most frequently used term of reference, re-ordered in line with the broader category of 'Black and minority ethnic'. This reflects the preference for ethnicity over 'race' as described above, and, as the most frequently used term in the literature included in this study, its usage throughout is an attempt to avoid confusion and ensure some consistency.

- Asian and Asian community

Aspinall (2002) warns against the use of pan-ethnic terms such as Asian and South Asian, however does state that these have regional saliency. Although he presents this as a challenge to the achievement of collective terminology, I would suggest that collective terminology should not necessarily be a goal we strive to achieve. In his paper, the author admits that 'diversity in terminological usage is probably inevitable, may be beneficial, and should not disadvantage the user when terms are clearly unambiguously defined' (2002:810). I agree with all but the final part of this statement, as when considering socially constructed groups and categories, ambiguity is both inevitable and necessary. Variation in understanding enables fluidity in definition, allowing change over time, and preventing essentialising and reifying definitions. Unambiguously fixing definitions can lead to stereotypical systems of representation developing (Hall 2013) and does injustice to those who do not 'fit' within these 'agreed' definitions. Intersectionality recognises diversity of experience, which requires us to be open to difference within defined groups. In addition,

even when terms are defined unambiguously, individual experience means that understanding and interpretation remains unique to each person.

With the acceptance that 'Asian' has only regional saliency, the frequent use of this term by the participants of the study provides evidence that it is understood as important to their localised identity. This is especially pronounced in the frequent reference to the 'Asian community'. The unique and individualised interpretations of what this means to the participants is explored in chapter seven, however the shared understanding that an 'Asian community' exists in the geographical location secures its use throughout this thesis. The participants refer to the 'Asian community' in reference to their shared Pakistani heritage and differentiate between this and the 'Bangladeshi community', which refers to another minority ethnic group residing in the locality with a statistical population higher than the national average.

Although there are notable exceptions to white people using the self-defining language of those from Black and minority ethnic groups, I believe that the language I have chosen to use avoids words that are loaded with a history of discrimination and oppression. I have instead attempted to choose language that enables some shared understanding with the participants and their informal interpreters of choice. As identified in the literature review, a shared language with professionals facilitates better relationships and more supportive and appropriate care (Willis et al. 2016a, Manthorpe et al. 2009, Pound and Greenwood 2016) even when the service user is proficient in English as their second language (Lawrence et al. 2009). This concept can be transferred from practice to social work research, and to the ethos of narrative interviewing, where developing trusting relationships are important in order to facilitate the sharing of personal experiences.

1.4 Chapter Summaries

1.4.1 Chapter 2

Chapter two explores the movement of people from Pakistan and the broader South Asian subcontinent to England, starting in the 16th Century and concluding with more recent

events located in the geographical area of the study in the North West of England. Understanding history is crucial when considering the construction of ethnic divisions, the impact these divisions have on members of minority ethnic groups, the development of people's individual and group identity, and the processes that underpin the systems of disadvantage. This chapter includes a consideration of the role legislation and policy has in both challenging and perpetuating division and disadvantage, alongside defining events both locally and nationally. There is an integration of evidence for the intersectional nature of migration throughout the chapter, in order to prevent reductionist interpretations of the nature of disadvantage as solely located in ethnic division. The concluding section of this chapter presents the local context within which the study is set.

1.4.2 Chapter 3

This chapter provides a review of the literature in relation to ethnicity and health and social care. As the project developed from my time working in intermediate care, the first section includes a short discussion of this provision. The second part of the chapter follows the Social Care Institute for Excellence (SCIE) guidelines for systematic research reviews, namely the process of qualitative synthesis. The scope of this part of the chapter is to identify and synthesise themes within the existing literature in order to locate the contribution of the current study. The search terms centre on health, social care and social work provisions in combination with ethnicity. Gunaratnam (2008) challenges research that over-emphasises the importance of ethnicity over other characteristics, however the rationale for this is to make explicit the diversity of experiences within these umbrella terms, similar to her concept of 'doubled research', which works with socially constructed group identities in order to provide support to contest them.

1.4.3 Chapter 4

Throughout the project it has been important for me as the researcher to understand my own position in relation to existing theories and philosophies. At times it has been challenging to integrate the differing perspectives I relate to; this chapter attempts to reconcile these concepts and discusses the key theorists that have influenced this study. Social constructionism is outlined, and social identity is considered, prioritising the work of

Richard Jenkins and Erving Goffman. Despite philosophical differences in the positions of Goffman and Jenkins with Pierre Bourdieu, his theory of capital contributes to my understanding of the intersectional influence of privilege on the nature of experience. Intersectionality is also explored in this chapter, as it is of fundamental importance to understanding the influence of feminist theory on the project. There are interconnecting themes between this chapter and the methodology, but it is hoped that by separating these, it adds clarity to both.

1.4.4 Chapter 5

Following on from the theories described in the previous chapter, this section focusses on the ontological and epistemological decisions required, before outlining the relationship to feminist perspectives. From this foundation, social work research as a discipline is explored and aligned with the narrative method chosen for this thesis. Dialogic performance analysis, the method used to analyse the participant narratives, is discussed in detail, and related to the theories in chapter four. This study uses interpreters chosen by the participants, a decision made in an attempt to address the imbalance of power between researcher and participant. This choice is considered in relation to research in the field of interpreting studies and the relevant health and social care legal frameworks. A summary of thematic analysis, utilising Braun and Clarke's (2006) six phase approach is included, as this informs the process of synthesising the individual participant's case analyses. The ethical basis for social work research, and the considerations specific to this study are outlined, using Hall's (2013) theory of representational systems as a means to understand the relevance of my privileged status. Finally, the chapter concludes with a step-by step guide to the research process.

1.4.5 Chapter 6

Dialogic performance analysis is most often used as a method to analyse case studies, and requires the use of large sections of transcript, to ensure that individual narratives remain together rather than being fragmented, as seen in other forms of narrative analysis. This chapter presents three of the participant case studies as examples of this process, preceded by a 'pen picture' of their interview. This level of analysis was conducted for all participants,

and summaries of each person are provided in the abstract to enable the reader to feel a connection with each individual when reading the shorter extracts from their interviews presented in the next chapter. The choice of participants presented in this chapter is justified, as the women's stories present the diversity of experience identified in the process of analysis.

1.4.6 Chapter 7

Thematic analysis of the participants' narratives generated four overarching themes; racism, the expectation of poor services, space and place and intersectionality. The first three themes and their component subthemes are presented in this chapter. Extracts from the interviews of all participants are used here, enabling a broader understanding of their experiences in relation to each other. At times the themes are closely connected, and due to the intense nature of the narratives that participants shared, many stories are used several times to evidence different themes. Because of the close involvement of interpreters, their input into narratives is also included. Social identity theory tells us that identity is developed in interaction with the environment and those around us, therefore the perspectives of both participants and their friend/family interpreters help us to understand their experiences more completely.

1.4.7 Chapter 8

Intersectionality is one of the four overarching themes, however due to its importance in understanding the experiences of the participants, it is explored in a separate chapter. The subthemes here do not correspond to different demographic groups, as attempting to develop a hierarchy of disadvantage is warned against by Kimberlé Crenshaw (1987), who developed the concept of intersectional oppression. Rather, the differential distribution of privilege and capital is used to help make sense of the varied narratives presented by participants, and the impact their encounters has had on their self-identity.

1.4.8 Chapter 9

This final chapter brings together findings from the present study with those of the literature review and other published work in order to challenge the current response to discriminatory service provision. Key messages are presented, namely the intersectional nature of racism, language acquisition and ability to challenge those in positions of privilege. These messages are then explored in relation to privilege, capital and representational systems to enable suggestions for future practice to be outlined. The chapter concludes with a review of the limitations of the project.

2. Context

2.1 Why Include History?

This thesis is underpinned by both a critical theorist and social constructionist perspective. This means that an understanding of people's behaviour and experiences in contemporary society, and more specifically the behaviour and experiences of the participants of this research project can be best reached by acknowledging the importance of history. In chapter four, the theories underpinning the project will be explored in more detail, but here it is important to outline why history is so important;

Social identity theorists understand individual and group identity as developed in interaction with others (Jenkins 2014). Our treatment by others, and responses to this treatment work in a dialectic to shape both our identity, and that of those we are interacting with. This happens on both an individual level, where our individual identity is shaped, and on a group level, where the expectations others have of our behaviour, based on perceived group membership, affects how they interact with us, how we respond to this interaction, and ultimately how we perceive ourselves.

Although intersectional in nature, the primary focus of this thesis is ethnicity, a characteristic described as a group by Jenkins, with minority ethnicities described as stigmatised by Goffman (1968). If we use Goffman's understanding of a stigmatised group, and Jenkin's understanding of the development of identity, we can see how the differential and discriminatory treatment of an entire group, based on their ethnicity would influence the identity of people defined within this group. Discriminatory and oppressive stereotypes based on ethnicity are not developed in a vacuum, they are learned, as described by Jenkins, in interaction with others. This means that both white privilege and discrimination against minority ethnicities can be passed on generationally and become embedded in the construction of our society. Malik (1996) extends this explanation by describing 'race' as constructed specifically as an outlet for inequality, with inequality existing as a precursor rather than developing as a result of ethnic division.

From a contemporary perspective, we can analyse past events and recognise discriminatory and oppressive behaviour and decision making from those in positions of

power and privilege. These behaviours and decisions are then developed into discourse and perpetuated by everyday interactions as described above. By critically exploring the history of a specific minority ethnic group in the UK and more locally, we can understand how we have arrived at the current context for the research project. It is also important within this exploration, to identify the influence of intersectional oppression and disadvantage, as a focus on ethnicity at the expense of acknowledging other factors can conflate the importance of one demographic over a more holistic and robust understanding of participant's experiences (Guneratnam 2003).

Here, a brief acknowledgement of the importance of categorisation should be raised. There has throughout history, been much fluidity in the use of specific labels to define ethnic (amongst other) groups of individuals. In order to better understand the experiences of the time, labels, along with other language must be seen in their historical context. In terms of ethnicity, part of this encompasses the definition of people now defined as Pakistani, as 'Indian'; until 1947 India was part of the British Commonwealth, and, post colonisation, was ruled under the 1859 Indian Government Act, by majority white, English men. The area defined as India was also a much more substantial land mass than in the present day. Following World War II, under Atlee's instruction in 1947, India was declared an Independent state. In the same year Pakistan became a separate state, followed some decades later by Bangladesh in 1971 (Spencer 1997). This is relevant to any interpretation of historical literature, as distinction between regions of India are not frequently made in early documentation. The participants of this thesis were all young children, living in what is now Pakistan during this redefining of borders, however this chapter explores the history that predates their births, beginning with the first documented arrival of Asians in the UK.

Additionally, it is important to consider representation here. The majority of early information available referencing migrants from the South Asian subcontinent is documented by British authors. This means that these texts should be considered as perspectives, rather than 'truths'. As identified by Hall (2013 cited in Hall, Evans and Nixon 2013), representation is never objective, and comes laden with the values of the author. If we apply Jenkins' (2014) understanding of identity here, we can understand how writing from the time may define and perpetuate discriminatory beliefs. It is because of this that

the following discussion is a critical exploration rather than a description of the available literature.

2.2 Early Migrants

The majority of literature relating to the migration of South Asian nationals to Britain begins with the increase in immigration observed in the 1950s. This increase is very relevant to the contemporary issues facing South Asian populations, and the participants of the study arrived in the UK during this period. Individuals from both the South Asian and African continents were present in Britain long before the start of the 21st Century however, and the reaction to these early arrivals can be linked to the relationship between minority and majority ethnic groups both during the 1950s and today (Spencer 1997).

According to Visram (2003) the first record of Indians arriving in Britain followed the creation of the East India Company (EIC), a shipping company that dominated overseas trade for two centuries. The birth of shipping from the Indian subcontinent meant travel was possible and these circumstances account for two groups of Indians arriving in Britain; ayahs, or servants/nannies who supported the families of the EIC workers in travelling overseas, and lascars or seamen, cheaply employed in India to work on the ships. This very first recording of South Asians in the UK is beset with division. The two identified groups of migrants both arrive as employees of white business owners with poor terms and conditions, suggesting that ethnic division also signified socio-economic difference. The Indian lascars were employed cheaply, which undercut the British seamen's wages, they were also treated poorly in comparison to the white workers which lead to some Indians leaving their employment on arrival in the UK. The ayahs also experienced difficulties on arrival in Britain; once their services were no longer required, their funded return journey was not always honoured (Visram 2003). In response to these challenges, The Navigation Act (1660) stated that ships must be crewed with at least 75% British seamen. Policies were also implemented, attempting to force families employing ayahs to fund return journeys. This differential and discriminatory treatment, lower pay and poor terms and conditions demonstrate how deeply rooted white privilege is present within our history, with legislation legitimising discriminatory behaviour by those in positions of power.

The 19th Century didn't only witness the increase of the poor immigrants; upper class visitors and scholars crossed the ocean to visit and to be educated in England, and the British nationals employed by the EIC also returned with Indian wives and their children. The post-Enlightenment interest in scientific rationality at this time may have had implications for the reception these migrants received; the theory of phrenology, introduced by Franz Joseph Gall in the late 18th Century had drawn attention, and despite being widely discredited had been adopted to support the superiority of the white population, this early scientific racism ties in with evidence of EIC employee decisions to send only their paler skinned offspring to be educated in England, with the darker skinned children educated at home (Visram 2003). Visram identifies that skin tone alone did not ensure acceptance and that status was linked to how 'English' these Indian migrants could become in terms of their language skills and mannerisms, with class playing a substantial part. Here we see evidence of intersectional difference impacting on the experiences of the poor employees of white overseas tradesmen compared to those with considerable socio-economic advantage, accessing education still denied to many poorer UK nationals.

2.3 The First World War

In the run up to World War I the shortage of British labour and military saw the immigrant seamen again in favour; as part of the commonwealth, and already in Britain, they were a readily available workforce and served throughout the conflict. Following the War, amendments to The Aliens Act 1905 began to have implications for the Indian workers, their employment was restricted and ability to unionise limited. In 1919, following the addition of further restrictions, with the shipping industry in decline due to the reduction in demand post war, jobs on the ships became increasingly scarce and Visram (2003) describes increased tensions between white and Indian seamen looking for work culminating in the 1919 riots, where violent clashes between the groups were recorded. The social circumstances at the time, the lack of available work, surplus workforce and poor state of the economy following the war are not unrecognisable characteristics, these issues resonate with uprisings and tensions throughout the history of migrants in Britain (Spencer 1997). More recently observed by the rise in popularity of Nationalist political parties such as the UK Independence Party (UKIP), British National Party (BNP) and pressure groups such

as the English Defence League (EDL), the ability of the national population to scapegoat minority groups is well documented (Modood 2010). As in contemporary society, the scapegoating of minority ethnic groups following the War invoked a reaction, similar to the Unite Against Fascism (UAF) response to the EDL, an opposition to the lascar oppression can be observed in the creation of the India Freedom Association, responding to the unfair treatment of the seamen under the Aliens Acts and campaigning against colonialism.

Further legislation passed in 1925 restricted the Indian workers even more severely, with seamen returning from voyages having to register as illegal aliens if they were not in possession of the appropriate papers. Visram identifies several examples of immigrants, having lived in Britain for decades, fought in the war, and with wives and children (often white) in the country, being held and forced to register as illegal. Legislation again demonstrated the prejudiced beliefs of government, with immigration controls being tightened to ensure that Indian immigrants were of 'good standing' and could speak English before being allowed into England for work or study, again emphasising the close link between class and race at the time. This language skill requirement is particularly relevant given the link between socio-economic privilege and possession of English language identified in this thesis. Similarities can be drawn here between this historical legislation and the recent introduction of the citizenship test 'Life in the United Kingdom' into immigration policy in 2005 (Brooks 2013) and confirmation of secure employment as a requirement for some migrants.

2.4 Post-war Britain; Race Relations v's Immigration Policy

Equality historian Spencer (1997) documents the history of immigration policy in Britain and highlights the influence of Empire Windrush in 1948 on the 1948 British Nationality Act, following which he believes Britain's legislation began a path towards reducing the rights afforded to nationals from British Commonwealth countries. In the same year as Windrush docked in Britain, there were also riots in the port of Liverpool, city of Birmingham and town of Deptford. Williams and Johnson (2010) report the introduction of a policy of dispersal in response, to avoid concentrations of newly arrived communities, in the hope that they would assimilate into the local culture. This indicates a belief that the newly arrived migrants were to blame for the violence, rather than the white nationals

involved. In 1949, under the Labour government, an interdepartmental committee was formed to explore immigration and find evidence with which to base a decision regarding whether legislation was required and between Windrush in 1948 and the eventual decision to legislate in 1961 (coming into force in 1962), immigration was debated in cabinet discussions on a further 37 occasions (Spencer 1997).

Both Spencer and Williams and Johnson point to discriminatory and self-interested positions from government as influencing decision-making. Notably both describe a dilemma faced by parliament; legislate against all migrants and face backlash from Ireland and Australia, a much-needed source of labour, or make a distinction in legislation based on colour, and be exposed as racist.

Rather than legislate, government initially instated a number of administrative processes to reduce numbers of immigrants; commissioners were sent to Commonwealth countries to negotiate implementing checks and processes which would delay applications. They also talked at length to prospective migrants about the poor conditions in Britain, the lack of employment opportunities and difficulties faced by existing immigrants, in an effort to prevent applications. A policy of repatriating illegal immigrants and criminals was also enforced. According to government documents it was hoped that these measures would prevent numbers of applicants and therefore remove the necessity to legislate. Throughout the decade these processes were increased systematically, adding more pressure to Commonwealth countries to prevent their nationals from coming to Britain.

Unrest in 1958 again raised the profile of immigration as an issue in the media, however government was reluctant to be reactive, Williams and Johnson again critique publications from the time, claiming that they accentuate the link between violence and legislation. Rather, the authors claim government was moved to 'construct a case' despite reports that 'restrictions on immigration would make no significant contribution to the reduction of crime' (Williams and Johnson 2010:111).

The Immigration Act was announced in October 1961, it restricted access by introducing a three tier immigration system with limited vouchers, the number of which was controlled by government. Category A migrants needed to possess a recognised skill or profession, Category B needed a job ready to come to, and the final Category C included all other

applicants. From Williams and Johnson's discussion it is apparent that the evidence collected on behalf of the government did not indicate any detrimental effect of immigration on the British population. Repeated reports highlighted the complete lack of evidence to support a change in policy or legislation, however despite this, successive governments implemented a system of policies intent on preventing the migration of black and Asian individuals from Commonwealth countries. The use of bureaucratic procedures, visits to countries in both South Asia and the West Indies demonstrate the lengths that politicians were willing to go to in order to persuade both Commonwealth country leaders and the public there not to consider migration. This amounts to institutional racism within government, the same government that three years later passed the first Race Relations Act (1965).

Throughout the 60s the contradiction of Immigration and Race Relations legislation continued, with the 1965 'Immigration from the Commonwealth Act' further restricting the movement of migrants in the same year as the first Race Relations Act was passed. In an apparent contradiction, government legislated to make a civil offence of publicly discriminating against a person because of their race, ethnicity or nationality, whilst displaying the most discriminatory behaviour in terms of the 1965 Immigration Act. This hypocrisy was again witnessed in 1968 when both immigration and race relations legislation were updated in the same year, the former narrowing further the definition of 'British' and the latter expanding the civil offence of discrimination to public services, employment and housing. This double standard can be used to question government's commitment to ensuring anti-discriminatory behaviour by the white population. Enoch Powell's infamous 'Rivers of Blood' speech to Parliament, a month after the 1968 Immigration Act was described as 'the most openly racist piece of legislation in Britain's post war history' (Malik 1996).

2.5 Migration Patterns

South Asian migrants had traditionally saved within the family to send one male to work in Britain, this male would then in turn save the fare to allow a family member (usually a son or brother) to join him. a biradari system operated in the settled areas, allowing small communities to develop, saving money to repatriate the dead and to support new arrivals

(Malik 1996). This system, encouraged by casual racism from the general public, could have served to perpetuate the idea of a homogeneous population. It was within this context that the participants of this research project and their families arrived in the UK, and links between the presumptions of homogeneity in the 50/60s, and the themes from the current project can be clearly identified. The research area is one of the communities originally developed in this period and the narrative of the community centre manager, not used during the analysis of this research, also describes this pattern of migration from his personal experience.

In academia, discussions had moved away from biological racism, (although some advocates, for example Enoch Powell, still lingered) and instead centred on the idea of culture (Malik 1996). Where experimentation had identified that there was no biological difference between ethnic groups, cultural differences were still apparent, and the debate evolved to explore whether these differences were relative or absolute. In 1968 the Home Secretary Roy Jenkins stopped the immigrant assimilation programme (introduced in the 1950s), favouring cultural diversity, however to have originally implemented a policy of assimilation, including the dispersal of migrants on arrival, the government must have, on an ideological level, accepted culture as a relative concept; that cultural characteristics were not absolute, because to assimilate to the environment is to change, to fit in, and adopt the characteristics of the resident population. Assimilation adopted the idea of British superiority and related discriminatory and oppressive assumptions based on ethnic difference. This was fuelled by the persistent links made by media and government between crime, poverty and coloured migrants, described by Bell Hooks as 'white is right' (1995). The existence of such a programme does however still indicate a belief in the preconditions described. The retraction of these policies and the introduction of diversity may be demonstrative of the first multiculturalist ideas; idealistically described by Andrew Heywood (2012:315) as 'based on the right of different cultural groups to recognition and respect'.

2.6 Multicultural Policy and Practice

It is clear so far that both the first migrants of the 1600s, and the migrants arriving in the 1950s and 60s were greeted with discriminatory treatment and contradictory expectations.

Both groups of migrants worked in challenging roles in the towns they settled in and contributed to the economy but faced prejudice from both attitudes of those around them and from national government policies. The migrants with low socio-economic status and experiencing the most intersectional disadvantage faced challenges as their ethnicity was promoted as the distinguishing characteristic differentiating them from the poor white population. An understanding of intersectional oppression here could have unified the poorer communities based on socio-economic status rather than dividing based on ethnicity. In both periods, unrest between poor white and minority ethnic groups was observed, with discriminatory attitudes and policies seemingly condoning this presumption of white privilege. This is a pattern of behaviour also observed more recently, particularly in the early 2000s in the research area, as described later in this chapter.

South Asian migrant groups settled in predominantly industrial towns in Britain including Bradford, Oldham and Rochdale and many brought their children and families to live with them (Visram 2003; Spencer 1997). The communities predominantly lived in neighbouring streets to the white population however rarely mixed, evidenced both by The Richie Report (2001) and the personal narratives of the participants of this thesis. Both describe segregation as perpetuated not only by the political ideology of the government, and the social links already discussed, but by practical factors. Migrants offered a cheap labour force and as such often took night work, in Oldham and Rochdale this consisted of factory work and low-grade hospital staff. The practical separation meant that the migrants often lived parallel lives to that of their white neighbours and explains the slow pace of English language acquisition for those in such low paid positions.

Modood (2010) and McGhee (2005) attribute a turning point for British policies on race and ethnicity and the birth of multiculturalism in Britain to one single act; the issue of a fatwa on Salman Rushdie by Ayatollah Khomeini on 14th February 1989. The initial publication of the Satanic Verses the previous year attracted some small national protests however international attention was raised following the fatwa, with publishers and translators in several countries being targeted, including the murder of Hitoshi Igarashi the Japanese translator. According to Malik (2009), until this point, the South Asian migrant families were relatively settled in Britain, they experienced racism however their children and grandchildren were integrating British culture into their lived experiences.

Against a backdrop of Conservative separatist and racial ideology, including Margaret Thatcher notoriously announcing, 'there is no such thing as community' and declaring that immigrants were 'swamping' Britain (Margaret Thatcher Foundation, 1987: online), the fatwa has been viewed as the catalyst for several underlying cracks to deepen into metaphorical ravines. Firstly, the second and third generation South Asians were integrating into British life, which concerned some Muslim parents as this to them represented moving away from the close association with Mosque and family life. The attention drawn by the fatwa led to what McGhee (2005) describes as a 'Muslim loyalty' discourse; representing a choice between returning to the traditional requirements of the Mosque, a denial of the importance of respecting religion, or, as some youths chose, a more radical path. Secondly, the government reaction to the affair was a desire to limit disturbance of peace in the country, concerns perhaps fuelled by the persistent discourse linking coloured groups with a propensity for crime and violence. This was managed by consulting with individuals from these communities to discuss what was needed to keep the peace. The individuals chosen were ambiguously titled and frequently self-nominated 'community leaders'; imams, elders and Mosque leaders. These predominantly older males made decisions in consultation with government and local councils about how to best support their 'community', with community meaning basically all South Asian people in the area.

This policy reinforced the idea of a homogeneous minority ethnic population but more seriously, the funding of faith and ethnic community groups encouraged individuals to view themselves in these terms, whilst concurrently excluding those who didn't feel comfortable fitting in with these categorisations. Gunaratnam (2003) expresses the dangers of conflating the homogeneity of ethnic groups at the detriment of other characteristics, and intersectional theorists such as Crenshaw (1987) identify the problems associated with failing to acknowledge the different experiences of those facing multiple oppressions. The representation of all Asian people by older Muslim males encapsulates the errors that these authors warn against, meaning that the ensuing policy agenda represented only the perspectives of those included in the consultations, with those experiencing the most challenging situations unrepresented.

The combination of forcing a choice between integration and Islam and financial incentives to identify with specific faith or ethnic groups as primary defining characteristics can be seen as a self-fulfilling prophecy. In areas with higher populations of minority ethnic groups, relative peace was observed however what also developed was a discourse of 'plural monoculturalism' (Sen 2007); cultural groups living in isolation but in close geographic proximity.

The emergence of multiculturalism as a political ideology can be seen as a clear way of establishing difference and distance between majority and minority ethnicities and some texts continue to present this as the choice of minority groups (Heywood 2012). Social identity theorists would disagree with this position (Gunaratnam 2003, Jenkins 2014) as they oppose the privileging of ethnicity over other characteristics as failing to acknowledge complexity. By adding an element of competition to the receipt of funding for communities, government ensured that integration was increasingly less likely. The persistent link made by government, perpetuated by the media between poverty, crime and ethnicity, also meant that to the white majority, minority groups appeared to be faring better in terms of funding their projects, further adding to the hostile environment that competing for money had fostered. This is the environment experienced by the research participants as described by both *The Richie Report* (2001) and the narrative of the community centre manager.

2.7 Ethnic Divisions and Public Health

A discourse of ethnic discrimination was also evident in health care; *The Black Report* 1980 (in Townsend and Davidson 1992), requested by the Labour government in 1977 investigated the health of the British public and the findings clearly demonstrated a firm correlation between class and health. Moreover, the report identified the relationship between class and ethnicity as having negative implications for the health of minority ethnicities. A higher proportion of the minority groups were in the lower socio-economic groups, therefore more likely to experience poorer health. The report also made note of both the ambiguity and lack of statistical data available in terms of ethnicity or religion with which to draw conclusions about the health of these groups. This is a debate that continued until the NHS made ethnicity one of its required demographic indicators in 1995.

In addition, steps taken to cover up the findings of this report align Williams and Johnson's (2010) belief that immigration policy consciously discriminated against the 'undeserving' and concealed evidence of ethnic disadvantage.

Further signs of the impact of multicultural agenda can be observed in public health campaigns of the 1980s. The idea of ethnic difference permeated its way into both health policy and research, presenting minority ethnicities as having different and predominantly worse health conditions than the white majority; 'people from different cultures have different disease patterns, different perceptions of health and illness, and different expectations and experiences of health services' (McNaught and Maingot cited in Rawaf and Bahl 1998:65). Although the above statement may be true, it is significant that discussion of the similarities in health between ethnicities is absent here. In line with a perspective of white privilege, statistics relating to disease and illness were also consistently presented in comparison to a white norm, failing to recognise the intersectional nature of health and illness outlined in *The Black Report* (1980).

Douglas (1998) conducted research into health promotion campaigns amongst minority groups and identified that campaigns from the 1980s including dietary advice to prevent rickets in South Asian babies and HIV advice for black males were both culturally inappropriate and presented 'negative images and stereotypes' (Douglas cited in Rawaf and Bahl 1998:96); by targeting specific populations about issues unrelated to mainstream campaigns. The conclusion that specific groups were alone in experiencing these diseases led to a blame culture, along with the concerning idea that only these groups were at risk. Douglas' research indicated that both first language identification of need, and consultation with the community involved could achieve more success in terms of participation in health services. These findings are in line with those from the present research project, conducted decades later. Interestingly both the problems and the solution as presented here have links with multiculturalist policies. Atkin (cited in Graham 2009) extends the link between criticisms of multiculturalist policy and health care when observing that awareness raising in health care is targeted, rather than generic, he also echoes Malik's assertion that passing information on to 'community leaders' diverts responsibility away from the responsible body, in this case the NHS, claiming that it is 'convenient to assume they are a representative sample' (2009:137). These links highlight the penetration of the

multiculturalist ideology into all areas of domestic life and are also representative of the research identified via the literature review in chapter three.

Authors such as Gunaratnam (2003), and intersectional theorists such as Crenshaw (1989) promote the acknowledgment of competing oppressions rather than the acceptance of ethnicity as the overarching characteristic to define a heterogeneous group. Alongside this approach, social constructionists (Burr 2002) understand ethnicity as a socially constructed group, with critical theorists contributing that the construction has developed to privilege the majority population at the disadvantage of all others. Additionally, social identity theorists (Jenkins 2014) describe the development of individual and group identity as dependent on interaction with others and defined at the borders of what we are not in a dialectic interaction. In this complex context, it is evident that despite the contestable nature of ethnicity, its existence has become part of people's lived experience and as such, research evidence into the impact of this contestable demographic on various aspects of life is required.

2.8 Contested Terms

One primary concern for researchers when referring to the Asian population is the delay in recognising the importance of collecting accurate information, this has been hampered by the staggered introduction of various terms. The decision was made in 1920 to allow ethnicity onto the British census, however this information was only collected 71 years later in 1991, until this time 'country of birth' was assumed to be adequate. In 1995 the NHS began to collect ethnicity data, using the eight categories from the 1991 census. In 2001 census categories were extended to 16, including identifiers for individuals of mixed heritage. The assumption being that as ethnicity data is required by the NHS on registration, the inclusion of additional categories of ethnicity would enable quantitative research into service usage and diagnoses. However, as Dowler and Spencer (2007) identify, significant amounts of information remain absent, in 2002, following further encouragement by the NHS to record ethnicity, still 32% of patients had no such data saved.

A further concern for quantitative data collection is the complex link between ethnicity and religion; Identifying ethnic differences in illness and disease pattern echo the biological

racism of the past and some elements of daily routine should be defined as religious rather than ethnic. For example; the dietary requirements of Muslim and Jewish groups, the fasting pattern observed by Muslims during Ramadan and religious festivals, holy days and prayer requirements also vary. The issues are further complicated by the differences in recognising these divisions in legislation; where Sikhs and Jews were recognised as 'races' in 1982, allowing them recourse to the protection afforded under Race Relations Acts, Muslims had to wait until 2003 to be afforded this same recognition, being open to religious discrimination with no purpose-written legislation to support prosecution until 21 years after other groups.

2.9 Community Cohesion and the Research Area

The events of September 11th 2001 are attributed with the move from a multiculturalist agenda to community cohesion. From the start of the 21st century there appears to be a duality of themes emerge in relation to minority ethnicities, and more specifically to Muslims. The first is that of community cohesion; in the aftermath of both the 9/11 attacks in America and the unrest in the north of England earlier in the same year, multiculturalist policies appeared to no longer be pacifying the public. Government instead made a clear policy move towards community cohesion (Bourne 2007), 'the idea that the nation[...]had a deficit of glue' (2007:5), and that this needed to be manufactured and filtered into society. Following the unrest in Oldham in May of 2001, David Ritchie and a panel of 'experts' reported their findings, many of which supported critics of multiculturalism, including the opinion that competition for funding drawn along faith or ethnic lines had increased unrest, and that the perception of 'the other side' getting a larger share of available moneys was evident in many areas of life, for example education and housing. Parallels can also be drawn from the report between the situation in norther England and the 19th century unrest in port towns, where lack of employment and opportunity led to violent clashes between Asian and white seamen. The Ritchie Report identified that Oldham Council were not leading by example, with minority ethnicities grossly underrepresented in its own workforce, even more so considering the higher than national average population of these groups residing in the town (Ritchie 2001).

So clear was the move to a different type of strategy that in 2002 the Local Government Association (LGA) issued the document; *Guidance on Community Cohesion*. This report identified how councils could improve their relationship with minority ethnic groups through strategic management plans and policy implementation. One such objective was to engage 'Community Representatives' and where multicultural policies were criticised for approaching inappropriate spokespeople (Malik 1997; Qureshi 1998). The LGA acknowledged this previous flaw and looked to approach young people directly to hear their views. In the weeks of the unrest in Oldham, Oldham Athletic introduced 'Unity in the Community' as one such community engagement project to actively promote both engagement and positive relationships between the young people from the different communities in Oldham. This thesis is recognised in the *Ritchie Report* (2001) as a positive step towards the community cohesion goal.

Despite such intentions, in 2007 the Commission for Racial Equality presented data that exposed 30 out of 47 local authorities not meeting their requirements under the Race Relations (Amendment) Act 2000, and that only 16% of Asians questioned would be likely to participate in local civic consultations, with 32% likely to participate in civic activities. The report continues by identifying that Asians are less likely to vote or be registered to vote than their white peers. In addition, at the time of publication (in 2007) the underrepresentation of minority groups in Parliament was such that it would take until 2080 to become representative of the country's population. One of the final recommendations of the report is a 'focus on improving community cohesion and integration' (2007:60), a task first set six years prior.

2.10 Terrorism and the 'war on terror'

Until 2000, more recent immigration legislation had been focussed on asylum seekers, however in the year of the 9/11 attacks on America and the unrest across England, government reviewed terrorism legislation for the first time since the 1993 Terrorism Act. This was then revised again in 2001, post 9/11 with the introduction of the Anti-Terrorism, Crime and Security Act (2001) as a reaction to both national and international events. The timing of this legislation explicated links between the extremists who carried out the attacks in America, terrorism and the unrest in the northern English towns, cementing the

association between Muslims and violence. The Ritchie Report (2001) included testimonies from young Asian men stating that they felt targeted by police, especially in terms of the use of stop and search powers in the town, this opinion was supported by evidence to suggest that there was a 300% rise in the use of this power to stop Asian youths between 2003 and 2004, adding to the perception of young people from ethnic minorities as violent. Here Bourne (2007:5) identifies the alternate position that rather than being perpetrators of violence, since the introduction of anti-terror legislation, 'a virulent and pervasive form of racism...has come to permeate British life' including 'increased attacks on Muslim institutions and people perceived to be Muslim'. This second understanding was reinforced by the narratives of one research study participant, who described the fear of her three sons being implicated in offences because of their physical appearance as young British Asian Muslims.

Throughout early 2000s the language used in policy and legislation also adopted a more protective tone, from the 2002 *'Secure Borders, Safe Havens'* to the 2005 *'Controlling Borders; Making Migration Work for Britain'*, the association between immigration and national safety are overtly apparent. McGhee (2008) furthers the argument by indicating that the vague and broad language of the anti-terror legislation is intentional in its ambiguity, serving to foster a state of fear and insecurity in the minority ethnic community about what behaviour is and isn't acceptable.

The Racial and Religious Hatred Act (2006) sees fundamentalist ideas increasingly linked to violent acts (Modood 2010). This implies that all strict or traditional observers of faith, and the Muslim faith in particular, have a propensity to violence. This idea is essentially encapsulated in the definition of 'inciting hatred'. Samira Ahmed (2013 online) identifies with this idea and transfers its relevance to arts and media, with Asian comedians and actors feeling unable to tackle issues unrelated to their faith, but simultaneously being reluctant to voice an opinion in respect of religion, due to the social implications, or, as McGhee (2008) would suggest, the ambiguous legal restrictions. Although the Act applies to all 'races' and religions, the timing of its introduction and the history of discriminatory policy and practices outlined throughout this chapter mean that it appears directed at the Muslim faith.

Knowledge of Language and Life (KOLL) testing was introduced in 2005 for new migrants to the UK (Webarchive 2013 [online]). Policies such as these signal the emergence of a more conditional acceptance and sense of uncertainty for new migrants. In a few decades the agenda moved from the multiculturalist idea that we should embrace ethnic differences and encourage faith and ethnicity-based activity through the community cohesion agenda that encouraged joint engagement in the community, sharing in a 'give and take' relationship to promote diversity, to this idea of conditional acceptance as British. This conditionality includes an expected level of knowledge and assimilation to the 'British way of life' and can be seen as a return to the expectation of assimilation observed by the immigrants of the 1950s.

One of the questions on the practice citizenship tests available online is a multiple-choice question asking what the requirements are of new migrants, the correct two answers were 'an understanding of written and spoken English' and 'a good knowledge of the British way of life' (British citizenship tests [online]). These requirements relate to the findings of this research project, as there are explicit links between socio-economic status and English language acquisition. There are also identifiable links between socio-economic status and confidence to travel outside of the Asian community, a community developed partly in response to the discriminatory treatment outlined in this chapter so far.

Both Spencer (1997) and Bourne (2007) identify links between Britain's stance on minority ethnic migration and the increasing relationship with Europe; Spencer states; Britain passed the 1971 Immigration Act restricting the movement of coloured migrants on the same day as joining the European Economic Community. Bourne discusses issues such as monitoring foreign students (and limiting their visas), language testing and pledging allegiance in a citizenship ceremony as distinctly European ideas. Additional evidence can be identified in two areas, primarily the access granted to eight Eastern European countries without work restrictions in 2004 (followed in 2007 by the restricted access of Bulgaria and Romania) sandwiched between two pieces of restrictive legislation relating to mainly non-European residents, or, more realistically coloured immigrants; the 2004 Asylum and Immigration (treatment of claimants etc) Act, and the policy; *'Controlling Borders: Making Immigration Work For Britain'* in 2005. Secondly the rise in Far-Right politics in the UK; prior to the formation of UKIP in 1993 and its recent rise in popularity, Britain did not have

a credible Far Right political party, it has now followed in the footsteps of European countries such as France, which banned the wearing of the hijab or face veil in 2011, and Denmark, where cartoon depictions of the Prophet Mohammed, deemed to be offensive by some groups, were published in a newspaper in 2005.

2.11 Contemporary Policy

Adult social care legislation in England and Wales was recently overhauled with the introduction of The Care Act (2014). This Act consolidated and revoked the existing legislation and is based on the underpinning principle of 'well-being'. It has specific duties relating to assessing adults and providing care and support based on their needs. Section 4 of the Act outlines the duty for local authorities to provide information and advice about the support available to meet the care needs of its population, and financial advice relating to funding this support. Subsection 4(4) outlines the requirement that this information and advice is 'accessible to and proportionate to the needs of those for whom it is being provided' (MHSC 2014). In relation to the Asian community in the research area for this thesis, this means that there should be accessible information readily available. A key aspect of accessibility is the provision of information and advice in the first language of the person requiring it. Additionally, in order to be accessible, the information and advice needs to be available in a place that those needing it are able and confident to access it. The results of this research project challenge the local authorities' commitment to meeting this duty, but other contextual factors and existing legislative influences also prevent this advice and information from being accessed by those from the Asian community.

As a member of the European Convention on Human Rights (ECHR), English law is required to ensure its national legislation does not contradict the articles of the ECHR. The current route through which this is enforced in England is via the Human Rights Act (1998). At the Conservative Party conference in 2013, in the build up to the general election of 2015, Theresa May (then Home Secretary) used the possibility of reforming this Act and replacing it with legislation that restricted the rights of immigrants within the criminal justice system to use Article 8, the right to 'private and family life' (Travis 2013 [online]). The timing of this announcement following the lengthy and well publicised extradition hearing of suspected terrorist Abu Hamza, culminating in his extradition to the USA in 2012 encouraged the

public to link human rights laws with enabling suspected criminals to remain protected. This reinforced the already constructed link between the Muslim faith and acts of terrorism, positioning adherence to European human rights laws as restrictive rather than empowering, a rhetoric that continued throughout the ensuing Brexit referendum campaigning.

During the campaigning in the run up to the 2016 'Brexit' referendum, immigration played a key role in politician's canvassing to the public and was monopolised by the far-right political party UKIP, then led by Nigel Farage. Immigration was the most frequently used Brexit cover story in UK print media and was depicted as overwhelmingly negative (Moore and Ramsey 2017). The emphasis was on public service pressures including the NHS, which was already frequently identified in the news media as struggling to meet demand. The campaigning material used by UKIP featured Farage superimposed over a road packed with non-white people, replicating Nazi propaganda lifted from a BBC documentary aired in 2005. It was deemed so racist and misleading in nature by UNISON, a public service workers union, that they reported it to the police for inciting racial hatred (Stewart and Mason 2016 [online]).

In the four days following the referendum, reporting of racist incidents rose 57% according to NPCC records (Moore and Ramsey 2017). Although the accuracy of crime statistics can be challenged, this increase in racism following incidents involving an ethnic dimension is not unique to the referendum.

2.12 Theoretical Perspectives

Applying social identity theory to this negative imagery, combined with heavily publicised terrorist attacks in France (November 2015), London (March and June 2017) and most recently Manchester (May 2017) provides a way of acknowledging the impact on both the Asian and Muslim population. Jenkins (2014) identifies that both individual and group identity is constantly evolving, based on interactions with both other people and our environment. This means that the discourse of fear generated by media coverage of the events above is embodied in the interactions between those perceived to hold the same group identity as those committing acts of terror and putting services under pressure and

the white population. Concurrently, because of the strength with which ethnicity is constructed as a group, members of the Asian community, and those of the Muslim faith recognise the similarities others are drawing between themselves and the perpetrators of terror offences and the refugees and asylum seekers blamed for the pressures on public services.

Following this theory, the impact of these messages to the Asian community contribute to the feeling of difference and discrimination, potentially being internalised to influence both individual and group identity. For the participants of this research project, this fear of reprisal could influence the women's decisions to remain within the perceived safety of their community and whether to consider services outside of this space.

2.13 Conclusion

Currently, The Equality Act (2010) functions as the anti-discrimination legislation in the UK; covering nine 'protected characteristics', of which race and religion or belief are included. This Act replaced generations of race relations legislation and consolidated all anti-discrimination laws into one comprehensive umbrella. The Act can be used to challenge direct discrimination by the public or in employment. Further, under section 149 it also charges public bodies not only with eliminating discrimination, harassment and victimisation, but also advancing equality of opportunity and fostering good relations between those with and without protection under the Act.

Although fundamentally positive, the implementation of new anti-discrimination policies alone cannot shift an entrenched discourse of inequality. As Moore and Ramsey identify, national and international events shape the behaviour of the population, specifically, events circulated with an identified racial aspect appear to trigger an increase of racist behaviour in the white population. Using this hypothesis, the combination of increased reporting of terrorist attacks as religiously motivated, and the use of refugee and asylum imagery in political campaigning can be expected to impact public perceptions and actions. The results of which are observable in the referendum and general election results.

3. Literature Review

3.1 Introduction

As the introduction to this thesis describes, the research idea was borne of my experiences as a social worker working in the research area and based in intermediate care as part of my role. This position enabled me to witness first-hand the lack of ethnic diversity in the service-user group and sparked my interest in exploring this further. Initially the project aim was to explore this under-representation, with the hope of promoting equal access to the service, in line with Equality Act (2010) section 149 duties for public bodies.

It soon became apparent that this would be an impossible task, it isn't possible to ask people why they don't use a service that they don't know exists with any research credibility. In response, the scope was broadened to explore the experiences of Pakistani older women in interaction with the health and social care services they had used.

It is therefore, fitting that the first part of this review details the evidence that lead to the development of the current project. This is followed by a systematic review that captures the literature relating to ethnicity and health and social care services. The review is guided by a traditional review protocol, as proposed by Rutter et al. (2010) with an intersectional lens applied, in order to acknowledge how multiple oppressions impact experience.

Part 1

3.2 What is Intermediate Care?

Intermediate Care stems from the findings of the National Beds Inquiry (1999) which identified that the number of inpatient hospital beds was not sufficient to supply the demands of an increasing population. The aging population and their increasing requirements for longer stays combined with indeterminate illnesses and a lack of community residential facilities necessitated a new way of managing their care.

This specific focus on older people and their care needs was swiftly followed up by the *National Service Framework for Older People* (NSF) in 2001, which outlined the requirement for community and home-based support services to enable older people to become more

independent, these services were to be referred to under the umbrella term 'intermediate care'. Intermediate Care was to have three main aims; to prevent 'unnecessary' hospital admission, to promote swift discharge, and to prevent premature admission to residential care. The NSF established the expectation of short term, multi-disciplinary rehabilitative services to provide predominantly older people with the necessary support to enable a return to their own homes. Service models include but are not restricted to residential rehabilitation, hospital at home, day hospitals and reablement support. The NSF document identified national targets for these services and pledged substantial funding and workforce to ensure their success.

Intermediate care is central to the government's prevention agenda and despite a limited and contested evidence base (Evans and Tallis 2001) it is consistently and increasingly encouraged as the default support mechanism for older people, this is evident in recent statutory duties under the Care Act (2014).

3.3 Ethnicity, the Census and Intermediate Care Policy

The 2011 Census identifies 5.3% of the combined English and Welsh populations self-define as British Pakistani. When considering more ethnically diverse areas such as the research area this percentage rises to 10.1%. Census data also records median age for each ethnic category and this data indicates that the Pakistani population have a significantly lower median age of 25 years, compared to the white British population which was recorded as 42 (Office for National Statistics 2011 [online]). This higher population of younger people from Pakistani heritage compared to the white population has an impact on the number of people from this population who require treatment or support via health and social care systems, as the majority of people using NHS and local authority services are older people.

The National Audit of Intermediate Care (NAIC), part of the NHS Benchmarking partnership was launched in November of 2011, the same year as the Census. This organisation annually records and publishes details of individuals admitted and discharged from various intermediate care units throughout England and Wales as part of its data collection. The NAIC is a voluntary audit and services are responsible for signing up and sending information to be processed, therefore its results are not necessarily as thorough as the

Census, however when observing the percentage of individuals using intermediate care services from the same ethnic groups identified above, there is a stark contrast in terms of representation. Only 0.56% Pakistani service users were identified as utilising Intermediate Care services. In real terms this equates to less than one person of Pakistani heritage accessing bed based intermediate care services out of 1537 individuals.

3.4 Table 1: Intermediate care access data*

Population	Pakistani
% England/Wales population (Census)	2.5
% research area population (Census)	10.1
% Accessing IMC	0.56
% Accessing Bed-Based	0.26
% Accessing Home-Based	0.86

**information sent as a response to a request to NAIC directly.*

Although as described above, there are some discrepancies in the accuracy of this information, aside from more philosophical discussions around the usefulness of demographic indicators, there is an undeniable underrepresentation of service users from Pakistani heritage accessing intermediate care services. In relation to Section 2 (2b) of the Care Act (2014) this raises concern; as explored above, the new legislation obligates local authorities to ensure that individuals with care needs are identified and offered support. This support should (in keeping with Section 2 (1)) endeavour to prevent, reduce or delay the need for care. This purely quantitative information would indicate that there are a significant number of individuals of Pakistani heritage who require but are not in receipt of intermediate care support, under the duties designated by The Care Act (2014) this needs to be addressed.

Part 2

3.5 Introduction

In 1998 the Department of Health commissioned an inspection of social services departments (now local authorities) to evaluate the extent to which their 'arrangements for planning and delivering community care services appropriately addressed the needs of ethnic minority older people' (DoH 1998:3). The findings were published in the report; *'They look after their own don't they: Inspection of community care services for Black and Ethnic Minority older people'* (1998). The report identified that in the eight boroughs inspected, there was evidence of planning support and services for people from minority ethnicities, but in practice there was little variety. Provisions that were available were often ethnocentric, making it difficult for those from different ethnic backgrounds to establish appropriate support. Black and minority ethnic service providers, who had successfully developed ways to support their communities experienced difficulties securing local authority contracts, which exacerbated the problems service users were facing with longstanding 'white' services.

The report acknowledged that most authorities did provide translated leaflets about their services, but that these were not effective because of lack of other strategies to engage with communities. There was also inconsistent use of interpreters and lack of understanding of when it was inappropriate to recruit family members to step into this role. Once involved in care management, minority ethnic older people's support was often dependent on the skill and confidence of the individual workers and there was a lack of cultural sensitivity. The title of the report; 'they look after their own don't they' is a direct quotation from a worker interviewed as part of the inspection, indicating the level of institutional racism uncovered. Basic services were not always suitable, and the availability of appropriate support decreased as need increased, meaning that those with high support needs were often most likely to receive unsuitable support.

The report also identified that although authorities possessed generic safeguarding and adult protection policies, there was little information relating specifically to challenging racism. Additionally, employment of minority ethnicities in the authority workforces was not representative of their population.

Although positively framed, the report highlighted significant disadvantage and discrimination in the provision of services to minority ethnic older people, however it did not analyse the data it collated for patterns of discrimination within the broader group of 'black and ethnic minority'. A more detailed intersectional analysis could have provided insight into the differential impact of disadvantage and oppression on the delivery of local authority support.

The research included in this review has been collected 20 years after the publication of this Department of Health document.

3.6 Methodology

This part of the literature review takes guidance from the SCIE Systematic Research Reviews guidelines (Rutter et al. 2010), specifically the guidance for conducting qualitative synthesis. Qualitative data synthesis 'involves identifying common themes across primarily qualitative studies' (2010:61) however extends this to develop 'a fresh contribution to the literature' by developing interpretations of the meaning reported by research evidence.

This review takes guidance from the process and rather than replicating it exactly, adjustments have been made to fit the requirements of this thesis. For example, two literature reviews have been included in the review, rather than excluding all but empirical evidence. Kelly (2013) describes the need to be flexible in approach when researching social work, in line with the inclusive nature of the profession. Additionally, the data extraction table (found in Appendix 1) includes columns relating to the 'participant type', which enables me to group articles in relation to the area practice being explored.

The review explores peer reviewed research that connects ethnicity to the field of social work and social care practice with adults. The search used CINHAL, Academic Search Premier, SCOPUS and Medline databases. The terms used are listed in table 2 with the number of articles generated once duplicates were removed:

3.6.1 Table 2: Literature Review Search Terms

Search terms	Number of articles
“ethnicity” and “social care”	69
“ethnicity” and “social work”	46
“ethnicity” and “residential care”	27
“race” and “social care”	21
“race” and “social work”	30
“race” and “residential care”	7

3.6.2 Filtering Process

Abstract reading removed articles based on the following criteria for exclusion:

- Conducted outside of the UK
- Focussed on a different and specific ethnic group only (for example articles about only Gurkha and Chinese older people were removed)
- Focus was only on children and families’ services
- Focus only on organisational/practitioner issues without considering impact on service users/carers
- Theoretical/discussion papers*

*these papers were retained as supporting literature.

This left 20 articles remaining. Through a snowballing process, five articles were identified that were absent from the database search using the parameters described above. Considering Kelly’s proposal that social work literature reviews should take a flexible and inclusive approach to incorporating relevant literature, I have added these five articles to the review, making a total of 25 papers, which are presented in table three in date order, with the most recent publication first.

3.6.3 Table 3: Literature Review Articles

Paper number	Reference
1	Larkin, M., Unwin, G., Iyer, M., Tsimopoulou, I., Zahid, S., Malik, K., Kroese, B. S. and Rose, J. L. (2018). Cultural affordance, social relationships and narratives of independence: Understanding the meaning of social care for adults with intellectual disabilities from minority ethnic groups in the UK. <i>International Journal of Developmental Disabilities</i> , 64(8) 195-203.
2	Malik, K. J., Unwin, G., Larkin, M., Kroese, S. B and Rose, J. (2017). The complex role of social care services in supporting the development of sustainable identities: Insights from the experiences of British South Asian women with intellectual disabilities. <i>Research in Developmental Disabilities</i> 63 74-84
3	Willis, R., Pathak, P., Khambhaita, P., Evandrou, M. (2016a). Complexities of Cultural Difference in Social Care Work in England. <i>European Journal of Social Work</i> . 12 57-70
4	Pound, C. and Greenwood, N. (2016). The human dimensions of post-stroke homecare: experiences of older carers from diverse ethnic groups. <i>Disability and Rehabilitation</i> 38(20) 1981-1999
5	Lipman, V. (2015). Contracts and commissioning: what's happening to social care services for black and minority ethnic older people? <i>Working with Older People</i> 19(2) 85-93
6	Greenwood, N., Holley, J., Ellmers, T., Mein, G. and Cloud, G. (2015). Qualitative focus group study investigating experiences of accessing and engaging with social care services: perspectives of carers from diverse ethnic groups caring for stroke survivors. <i>British Medical Journal Open Access</i> 6
7	Willis, R., Evandrou, M., Pathak, P. and Khambhaita, P. (2016b) Problems with measuring satisfaction with social care. <i>Health and Social Care in the Community</i> 24(5) 587-595

8	Manthorpe, J., Moriarty, J., Stevens, M. Hussein, S. and Sharif, N. (2012). Promoting the mental well-being of older people from black and minority ethnic communities in United Kingdom rural areas: findings from an interview study. <i>Journal of Rural Studies</i> 28 406-411
9	Gunaratnam, Y. (2011). Cultural vulnerability: a narrative approach to intercultural care. <i>Qualitative Social Work</i> 12(2) 104-118
10	Manthorpe, J., Moriarty, J., Stevens, M., Hussein, S. and Sharif, N. (2010) Black and minority ethnic older people and mental well-being: possibilities for practice. <i>Working with Older People</i> 14(4) 31-38
11	Manthorpe, J., Iliffe, S., Moriarty, J., Cornes, M., Clough, R., Bright, L. and Rapaport, J. (2009). 'We are not blaming anyone, but if we don't know about amenities, we cannot seek them out': black and minority older people's views on the quality of local health and personal services in England. <i>Ageing and Society</i> 29(1) 93-113
12	Barn, R. (2008) Ethnicity, gender and mental health: Social worker perspectives. <i>International Journal of Social Psychiatry</i> 54(1) 69-82
13	Gunaratnam, Y. (2008) From competence to vulnerability: Care, ethics and elders from racialized minorities. <i>Mortality</i> 13(1) 24-41
14	Atkin, K. and Chattoo, S. (2007) The dilemmas of providing welfare in an ethnically diverse state: seeking reconciliation in the role of a 'reflexive practitioner'. <i>Policy and Politics</i> 35(3) 377-393
15	Merrell, J., Kinsella, F., Murphy, F., Philpin, S. and Ali, A. (2006) Accessibility and equity of health and social care services: exploring the views and experiences of Bangladeshi carers in South Wales, UK. <i>Health and Social Care in the Community</i> 14(3) 197-205
16	Laurence, V., Murray, J., Banerjee, S., Turner, S., Sangha, K., Byng, R., Bhugra, D., Huxley, P., Tylee, A and Macdonald, A. (2006) Concepts and causation of depression: a cross cultural study of the beliefs of older adults. <i>The Gerontologist</i> 46(1) 23-32

17	Hoong Sin, C. (2006). Expectations of support among White British and Asian-Indian older people in Britain: the interdependence of formal and informal spheres. <i>Health and Social Care in the Community</i> 14(3) 215-224
18	Mold, F., Fitzpatrick, J. M. and Roberts, J.D. (2005). Minority ethnic elders in care homes: a review of the literature. <i>Age and Ageing</i> 34 107-113
19	Alam, S., Fagan, T. and Sainsbury, S. (2005). Not just a technical fix: Rethinking rehabilitation for visually impaired people from minority communities. <i>International Congress Series</i> 1282 355-359
20	Beattie, A., Daker-White, G., Gilliard, J. and Means, R. (2005). 'They don't quite fit in the way we organise our services' – results from a UK field study of marginalised groups and dementia care. <i>Disability and Society</i> 20(1) 67-80
21	Forbat, L. (2004) The care and abuse of minoritized ethnic groups: the role of statutory services. <i>Critical Social Policy</i> 24(3) 312-331
22	Livingston, G., Leavey, G., Manela, S., Sembhi, S. and Katona, C. (2002). Accessibility of health and social services to immigrant elders: the Islington study. <i>British Journal of Psychiatry</i> 180 369-373
23	McGrother, C. W., Bhaumik, S., Thorpe, C. F., Watson, J. M. and Taub, N. A. (2002) Prevalence, morbidity and service need among South Asian and white adults with intellectual disability in Leicestershire, UK. <i>Journal of Intellectual Disability Research</i> 46(4) 299-309
24	Burr, J. (2002). Cultural Stereotypes of women from South Asian communities: mental health care professionals' explanations for patterns of suicide and depression. <i>Social Science and Medicine</i> 55 835-845
25	Goldstein Prevatt, B. (2002) Catch 22 – Black workers' role in equal opportunities for Black service users. <i>British Journal of Social Work</i> 32 765-778

3.6.4 Extraction Process

Once the articles were identified, an extraction table was created (see Appendix 1), based loosely on the examples provided by Rutter et al. (2010), but adjusted to fit the purpose of this thesis, as discussed earlier.

In line with Rutter et al. (2010), papers were rated either strong, medium or low in relation to both quality and relevance. Quality was based on the inclusion of a clear methodology for both data collection and analysis, the use of direct quotes from participants, and acknowledgment of any limitations of the study. Relevance was based on the focus of the paper compared to the current project in terms of both service user group (for example several papers related specifically to individuals with learning disabilities or mental health diagnoses) and ethnic group (for example some papers comparative in their approach and included participants from different ethnic groups whereas others included participants from only one ethnic background, e.g. Indian-Asian, Bangladeshi or African-Caribbean).

3.7 Synthesis

Once the relevant data was extracted from the table, the information was separated into themes. This process utilised the 'findings' section of the extraction table; starting with paper 1, each finding was used as a theme, paper 2 themes were then compared, any similar results were added to the paper 1 themes and any new results became a new theme. This process was repeated with the findings from each paper, until all articles had been subject to the process. On completion of this process ten themes developed;

1. The nature of culture
2. Similarities across cultures
3. Intersectionality
4. Language barriers
5. interpreters
6. Cultural competence
7. Training
8. Racism
9. Cultural expectations of care giving
10. Relationships

Several of these themes overlap, for example relationships were found to be important in providing good quality care independent of the cultural background of the service user, but relationships are also difficult to foster over a language barrier. Despite the overlaps in the themes, they are presented separately for clarity in the following subsections. Each theme from the original extraction has been retained for transparency and they are presented below in the order that they appeared.

3.7.1 The Nature of Culture

Four of the studies (1,2,13,24) discussed the concept of culture and challenged essentialist perspectives of this as 'fixed and immutable categories' (Burr 2002:835) assumed by those of specific ethnic groups. Interestingly two of the four studies were the most recent publications, indicating a small but potentially significant shift in thinking about culture in practice-focussed research, particularly in relation to learning disability, the practice arena that the two studies explore. Larkin et al. (2018) suggest that the concept of culture is context dependent, demonstrating via case examples that individuals with learning disabilities were able to make decisions about when it was necessary to adhere to 'cultural norms' and when they could adopt a more flexible position. The researchers propose that a good quality care environment can support individuals to make context dependent decisions and offer the term 'cultural affordance' to define this process. Malik et al. (2017) allude to a similar concept and support the notion that culture is 'dynamic not static' (2017:78). This research also identifies the role that services can play in supporting individuals from minority ethnicities to sustain complex identities even when residing away from the family home. The participants of both articles were individuals with learning disabilities and were of South Asian heritage.

Gunaratnam (2008) and Burr (2002) consider the negative implications of adopting an essentialist perspective of culture. Gunaratnam (2008) refers to the danger of an over-focus on achieving cultural competence, specifically in relation to cultural knowledge, one of the facets of cultural competence identified by Kim-Goodwin et al. (2001). The author compares this to an abstract system and asserts that concentrating on establishing 'facts' about a culture fails to identify the importance of individual and relationship-based work and can constrain the provision of care. She proposes as an alternative, that lack of

knowledge, and embracing a passive position can facilitate more inclusive and individualised care relationships as this enables the service user to describe their own individual cultural needs and practices.

Grounded in the field of mental health practice, Burr (2002) extends Gunaratnam's warning against prioritising cultural knowledge to identify that cultural stereotypes based on 'cultural knowledge' are so entrenched in practice, that the adoption of these stereotypes as 'facts' has the potential to influence practitioners in relation to diagnosis and care pathways in mental health practice.

Although only a low number of articles discussed this theme, it is important to acknowledge that where practitioners and services were open to viewing culture as flexible and individualised, they were able to support service users to maintain their cultural practices. In comparison where culture was perceived as fixed, there was a danger of becoming fixated on requiring facts about the cultural background of individuals in order to provide appropriate care. Additionally, where these fixed cultural beliefs became entrenched, this could lead to discriminatory decisions about diagnosis and care provision.

3.7.2 Similarities across cultures

Leading on from the first theme, where the nature of culture was considered, the eight articles that provided evidence for this theme all included a cross-cultural aspect (4,6,8,10,11,19,20,22). This enabled researchers to identify similarities between ethnic groups. The specific similarities presented in the literature are:

- Challenges navigating the health and social care system
- Poor services
- Funding cuts
- Loneliness
- Access to services

Four articles indicated that participants from several ethnic backgrounds, including the White British population had difficulty navigating the health and social care system. For Pound and Greenwood (2016) and Greenwood et al. (2016) this related to services for carers and survivors of stroke. Both articles identify that stroke patients and their informal

carers from five different ethnic backgrounds had experienced difficulty understanding the systems involved in accessing health and social care. In some cases, this resulted in individuals weighing up the effort involved in attempting to seek support against the need for such support. Manthorpe et al. (2009) undertook a large-scale mixed methods project across ten local authorities and identified similar results across the spectrum of both ethnic backgrounds and service user groups, specifically in relation to accessing information about services. This challenge was also relevant in the field of visual impairment; Alam et al. (2005) explored visual rehabilitation services and identified that service users from minority and majority ethnic backgrounds found the way information was provided about services confusing.

There was limited support for a shared experience of poor services, with only one paper indicating that this was a cross-cultural issue; Greenwood et al. (2016) identified that poor and unsuitable services were a challenge for carers of stroke patients, however this may relate to the lack of service provision for this specific group, rather than a generalisable outcome.

Only one paper identified cuts to funding as a cross-cultural issue; Beattie et al. (2005) explored dementia provision by interviewing professionals. The researchers found that participants understood the impact of funding cuts, particularly to transport services, as a universal challenge for the health and social care sector.

Two papers identified isolation as a shared challenge. Manthorpe et al. (2012) and Manthorpe et al. (2010) utilised the same data set of interviews with service users, carers and practitioners in four rural local authorities to identify in both papers that isolation was a concern across ethnic groups. This indicates that the impact of location was a more important factor in considering loneliness a concern, in this instance the rural setting of the research meant that older people of all ethnic backgrounds may be at risk.

Finally, one study, Livingstone et al. (2002) identified that in an urban setting with a high percentage of minority ethnic communities, minority ethnic older people were equally likely to access primary and secondary health services as the white majority population.

Overall the eight articles that identified similarities between ethnic groups in relation to their experiences of services span a variety of service user groups. Aside from the

Livingstone et al. (2002) study, all the similarities identified referred to negative experiences. This indicates that in some situations ethnicity is not a deciding factor in whether services are perceived to be poor or difficult to access or confusing or whether someone is considered at risk of a specific need developing, as in Manthorpe et al. (2012, 2010).

3.7.3 Intersectionality

Intersectionality; defined by Crenshaw (1989), describes the complexity of experiencing multiple disadvantages and the inadequacy of attempts to tackle oppression based on prioritising one characteristic over others.

Four articles referenced intersectionality (2,12,15,24) and indicated that ethnicity alone was not sufficient to describe and analyse the experiences of their participants. The participants in two of these articles were South Asian women (Malik et al. 2017 and Burr 2002) in one (Merrell et al. 2006) 16 out of the 20 Bangladeshi carers interviewed were women and in the final article Bangladeshi social workers were interviewed (Barn 2008).

Burr (2002) explores the experiences of South Asian women with mild/moderate learning disabilities. In the interviews, the women were able to identify that their cultural identity was not just influenced by their ethnicity or religion, but that their gender and disability also had an impact. The participants understood their disadvantaged position in relation to not only male South Asians, but able-bodied female South Asians.

The identification of multiple disadvantages was not limited to participants with learning disabilities. Merrell et al. (2006) expose the gendered challenges facing Bangladeshi informal carers in relation to communication. Here the researchers identify that the female carers were less likely to be able to communicate in English; where all the men could speak English, for women this was age dependent, with the younger generation of informal carers possessing this skill and the older women having to depend on younger relatives to interpret. This has implications for older female carers, as their support was found to be delayed until an interpreter could be sourced and, where the older women could not read English this resulted in missed appointments.

In both Malik (2017) and Merrell et al. (2006) the participants were aware of the intersectional nature of their experience. The following papers; Burr (2002) and Barn (2008) indicate that practitioners in the mental health field are also aware of this. Barn (2008) reports on factors influencing the mental health of Bangladeshi women, describing a multiplicity of indicators including poverty, racism and gender. Of particular importance was the stigma attached to seeking help, particularly in relation to domestic violence, where the results of Merrell et al. (2006) in relation to language skills are particularly relevant. More women were identified as lacking the language skills needed to contact support services, particularly those from lower socio-economic groups, and therefore these women were dependent on other, often male family members and are described as in increased risk of mental ill health.

Burr (2002) refers to figures indicating high suicide rates for South Asian women, paired with low rates of contact with mental health services. Results indicate that the entrenched gendered, ethnic stereotypes of South Asian women as oppressed and bound by a culture of patriarchy could manifest in the misdirection of these women at both diagnosis and treatment stages. Where Barn indicates that there are challenges in making contact with South Asian women, Burr warns against making assumptions based on intersectional oppression and presumptions of western superiority.

In combination, it appears that South Asian women themselves understand the complex intersectional discrimination they face, but that practitioners and services continue to make assumptions about their needs based on discrete categories rather than individualised requirements.

3.7.4 Language Barriers

Seven of the articles referenced language barriers as playing an important role in influencing service users and carers experiences of services (3,4,6,7,11,15,16). Merrell et al. (2006) identified this as one of three key issues for Bangladeshi carers, who felt that being unable to communicate in their first language with practitioners meant that access to services was delayed and/or more complicated. This is an issue echoed by Greenwood et al. (2016) who found that although many challenging aspects of negotiating the care

system were universal across ethnic groups, the added impact of being unable to communicate exacerbated these issues. Some of the carers interviewed for this research proposed that employing carers who could speak the same language would not only prove helpful practically and support relationship building but would also facilitate a more trusting relationship and enable discussion of more sensitive care needs. This perspective is supported by Pound and Greenwood (2016), where both stroke patients and their carers felt that building relationships without a common language was time consuming and challenging. In situations where individuals have high care needs, this can be an added pressure at a difficult time. Interestingly, while some participants from Greenwood et al.'s (2016) study indicated that trust was facilitated by ethnic similarity, others identified that the opposite may be true. One participant believed that 'care workers sometimes took advantage of families from their own background, knowing that they were less likely to complain' (2016:5). This mixed response stresses the importance of recognising the heterogeneity of minority ethnic service users, outlined in the first theme.

The research indicates that the challenges related to the language barrier are not unique to accessing or experiencing care provision. Willis et al. (2016b) attempted to evaluate satisfaction levels with adult social care. Through semi-structured interviews they found that the lack of common language proved a challenge for ascertaining accurate feedback, with the researchers considering the use of intonation lost in these circumstances. This has significant implications for practice; where feedback from a section of the community is absent or inaccurate, this means their voices are absent in suggesting improvements to services. In turn this may mean that services are not developed in response to their needs, as they are for the English-speaking population, resulting in under-representation due to unsuitability rather than a lack of need.

From their large-scale cross-cultural study with older people, Manthorpe et al. (2009) ascertain that information about services and support needs to be meaningful and relevant to the people it is meant for, rather than a direct translation of the English version. Lawrence et al. (2006) contribute here by suggesting that adding meaning remains important even when individuals from minority ethnicities can communicate in English. In their cross-cultural interviews with older people experiencing depression, they found that individuals from different ethnic groups had developed variations on the vocabulary

associated with their illness. They identified that the use of terms such as 'hopelessness and low mood' were used by white and Black-Caribbean participants more frequently to refer to depression whereas South Asian participants preferred the term 'worry'. These differences in word preference may appear minor but can be significant in helping practitioners and service users develop a shared understanding of the presenting symptoms.

When practitioners were asked by Willis et al. (2016a) to describe the challenges presented by the language barrier, they identified that the use of language was important as it was their tool to negotiate with service users, with some practitioners describing the difficulties as making their 'work impossible, because they wield language as a tool to achieve their professional goals' (2016a:11). The participants also identified that giving advice and offering support were inhibited where they didn't share a language with service users and their informal carers.

The evidence suggests that the challenges presented by lack of shared language are wide-reaching at all stages of interaction with the health and social care system. Research indicates that accessing services, receiving appropriate information and care provision are negatively affected, as is the opportunity to provide feedback on these challenges. The papers identify that information should be meaningful and relevant, and that care should be taken to ensure shared meaning even when service users and professionals do have a shared language. Service users and carers suggested that where there was shared language, there was also a smoother relationship forming process, and that this then facilitated the development of trust.

3.7.5 Interpreters

The literature offers a variety of potential solutions to the challenges faced by the language barrier. In six papers, participants understood interpreters as part of the solution, but indicated that this was not without challenge (8,11,15,18,22,15). One concern in two of the papers was the limited access to interpreters, and the resulting delay in provision of care. In their research with older people and their carers Manthorpe et al. (2012) identified that access was poor and associated this to the rural location of the research, commenting

that there were 'complaints that access to interpreters and translators was poor compared to more urban areas' (2012:409). Interestingly the same researcher had identified a similar issue in hospital settings in earlier research; Manthorpe et al. (2009) found that although carers reported that hospital interpreting services were 'good', practitioners disagreed, stating that 'there is only one translator for each language' (2009:102). This limited resource meant that patients and practitioners had to book interpreting services days in advance. While the patients interviewed felt that this was acceptable, practitioners understood it as posing a challenge to the demands of hospital discharge policy and delaying the arrangement of care and support.

The identification of limited interpreting resources in both rural and hospital settings indicates that this is a more widespread issue. In their interviews with Bangladeshi carers, Merrell et al. (2006) reported that none of the participants had received formal interpreting support when accessing health and social care services, finding that participants were instead expected to rely on informal support. This informal support was often provided by children, and in one case by another adult with a mental health difficulty which lead to additional pressure and stress for these family members and delays in the arrangement of support. Conversely, Manthorpe et al. (2012) identified that one local authority and implemented a 'policy to avoid using family as interpreters' (2012:409), believing this to be in the interests of protecting service users. Manthorpe et al. (2012) and Merrell et al. (2006) report opposite ends of a spectrum here, with the former finding a total ban on family interpreting and the latter reporting only informal support. The dissatisfaction of participants with both options may be due to the lack of flexibility and individualised approach. There are inevitably times within health and social care practice, when a formal interpreter is required to ensure that service users are safeguarded, for example when there are concerns relating to abuse. However, there are also times when a family member may be best placed to provide language support, for example when the information to be discussed is of a sensitive or personal nature. Taking a more balanced approach, considering the needs of the individual and their family and explaining the rationale for decisions made is likely to achieve a more successful outcome.

Mold et al. (2005) conducted a literature review of research exploring the experiences of minority ethnic individuals in residential care. In the findings from UK literature, a shortage

of interpreters was identified as a challenge in residential settings. The solution posed by the papers reviewed was to employ more care workers from different minority ethnicities, who had a shared language with residents. This approach is contested by research by Goldstein (2002) with Black care workers. In this study the employment practice of recruiting minority ethnic care workers to promote equal opportunities for service users of the same ethnic heritage was found to add additional stress to the workers and resulted in them experiencing negative working conditions.

This theme identifies the implications of poor access to interpreters and demonstrates that there is conflict within the literature. This conflict relates to both service users' desire for support from practitioners with a shared language and the appropriateness of employing such a strategy. What is clear is that enabling and facilitating good communication between minority ethnic service users and professionals is essential. This point is demonstrated by Livingstone et al. (2002) who excluded 15% of participants from their interviews with older people because there was no interpreter available to capture their views.

3.7.6 Cultural Competence

Twelve of the studies included in the review identified cultural competence as important (3,9,11,12,13,14,15,18,19,21,23,24). The papers reflected this position in two different areas of focus; the knowledge of practitioners and the appropriateness and responsiveness of services. These categories are used as sub-themes here to help make sense of the broad spectrum of literature.

3.7.6.1 Practitioner Knowledge

Cultural competence is a contested term and most papers alluded to the challenge of definition. Kim-Goodwin's (2001) definition of a three-facet approach was referenced by both Gunaratnam (2011; 2008) and Willis et al (2016). This approach describes cultural competence as a combination of cultural knowledge, skills and sensitivity. Gunaratnam (2008) describes the majority of organisations focussing their expectations on one facet of this approach; cultural knowledge. This is presented as a misdirection by the author, who believes this misdirection requires an understanding of culture as fixed and essentialist. She describes a preoccupation with acquiring knowledge about specific cultures prevents

workers in end of life services from developing relationships and providing care for service users.

This is a position supported by Willis et al. (2016) who identified that practitioners felt unable to provide appropriate support for stroke patients and their carers without knowledge of their culture. They described that 'cultural differences are presented as a challenge to successful care' (pg12), with practitioners lacking confidence to ask about specific practices through fear of appearing ignorant or racist. Emphasis here is on the perception of cultural knowledge being required by workers, rather than the necessity of this knowledge.

Although Gunaratnam indicates that focussing on knowledge requirements prevents successful care provision, the understanding of its importance is shared by both practitioners (described above) and service users. In Merrell et al.'s (2005) interviews with Bangladeshi carers, the participants felt that receiving support from a worker with a shared ethnic background would ensure a more culturally sensitive approach to care. This indicates that the construction of 'cultural competence' and of cultures themselves as fixed and tangible is entrenched within society.

Some of the evidence (Gunaratnam 2011; Atkin and Chattoo 2007; Mold et al. 2005) offered solutions in relation to cultural competence challenges that reflect the division between those that understand culture as fixed, and those that accept a more fluid and individualised approach. In their review of residential care provision, Mold et al. (2005) identified the need for a culturally competent workforce in residential settings but reduced this to the requirement for understanding different food requirement, religious practices, interpreting services and the employment of more minority ethnic care staff. Conversely, when exploring work with minority ethnic children and families, Atkin and Chattoo (2007) recommended that practitioners become more reflexive in their practice. Describing the requirement for professionals to challenge their own values and considers the necessity for workers to become aware of western assumptions embedded in their practice.

Gunaratnam extends this requirement of reflexivity and proposes the term 'cultural vulnerability', describing the need for practitioners to be receptive to service users sharing their individualised needs. Vulnerability refers to the practitioner's position as open to the

differential adoption of cultural practices by service users and their carers. The author warns against accepting canonical narratives in relation to cultural expectations as these were identified as detrimental to providing individualised support.

The literature presents a spectrum of understandings in relation to cultural competence, from research adopting an essentialist understanding of culture (Mold et al. 2005), leading to an over-focus on cultural knowledge as immutable facts (Gunaratnam 2011), to papers proposing a position of cultural vulnerability where culture is understood as personal and fluid, leading to a requirement of reflexivity from practitioners. Burr (2002) demonstrates that when 'fact based' knowledge becomes assumed and embedded in practice, this creates stereotypes about cultural difference that result in misdiagnosis and inappropriate treatment. This highlights the importance of work such as Gunaratnam (2009) and Atkin (2007) in challenging practitioners to adopt a different approach to their interactions with minority ethnic service users.

3.7.6.2 Appropriateness and Responsiveness of support

According to Barn (2008) 'the provision of adequate and appropriate health and social care intervention to ameliorate the situation of those in need remains the ultimate aim of service providers' (2008:77). Despite this aim, all papers discussed in this sub-theme identified accessibility of services as a challenge (11, 12, 15, 18, 19, 21, 23) and relate this to the to cultural competence of either workers or entire organisations.

In her 2004 paper Forbat argues that the discriminatory treatment of minority ethnic people by health and social care organisations should be reframed as 'a fusion of abuse and institutional racism'. The author describes how the lack of cultural competence in recent health and social care policy results in discriminatory provision of support. Although written before the introduction of both The Care Act (2014) and The Equality Act (2010) the message in this paper is still pertinent today. Forbat refers to the assumption laid out in the now revoked Carers (Recognition and Services) Act (1995) that informal carers 'choose' to care. Here she argues that this presumption of choice fails to recognise the pressure carers feel to undertake caring roles and reinforces the stereotypical assumptions that minority ethnic families prefer to use informal care networks, leaving them removed

from the support of formal service provision. Despite the advances in the positioning of carers under The Care Act (2014), this presumption was identified within this literature review and is discussed in theme 10.

Alam et al. (2005) raises similar questions about the direction of policies relating to minority ethnic individuals with visual impairments. Here the researchers describe the change in direction from promoting the importance of group rehabilitation for visually impaired service users towards a focus on work and employment. This is framed as detrimental to minority groups, including ethnic minorities, as community rehabilitation is used as a social activity for many individuals, particularly those from minority groups, who are now perceived to be more vulnerable to isolation as a result of this shift in policy focus.

In their research with older people and their carers Manthorpe et al. (2009) found that the participants understood the challenges they faced trying to access support as due to poor strategic decision making, rather than levelling criticism at individual professions or practitioners. Recent cuts to funding were seen as having a greater impact on minority ethnic groups, a finding reinforced by Lipman's more recent (2015) research with practitioners from specialist Black and minority ethnic services. Lipman identified that these services faced greater funding cuts than mainstream services, whilst mainstream services were reducing specific provisions, leaving service users with limited choice of support.

Manthorpe et al. (2009) propose a number of explanations for the under-representation of minority ethnic individuals in health and social care services. Participants described finding the systems difficult to navigate with a lack of relevant and meaningful information. Concerns centred around financial contributions, with researchers also proposing that the older generation may still be affected by historic organisational racism. Finally, the only finding relating to the competence of individual practitioners was reference to 'inadequate preparation'. Here participants felt that practitioners gave little consideration to the adjustments they may have to make to their usual assessments in order to support minority ethnic service users. This is illustrated by Barn (2008) who's research with Bangladeshi carers highlighted the different terminology used to refer to mental health conditions. Lack of practitioner awareness of word choice preferences could potentially influence

assessments, for example the use of the term 'worry' to refer to depression could be overlooked without attentiveness from professionals.

Barn's (2008) reference to low acceptance of mental health services also reflects Manthorpe et al.'s (2009) identification of under-representation in provisions for older people. Barn (2008) does present examples of well attended services, and connects this to community engagement, describing joint work with local mosques as important. This research highlights the importance of recruiting minority groups to help shape health and social care services, but also describes the difficulties in engagement.

McGrot et al. (2002) explored the representation of minority ethnic people in learning disability services. Their findings lend some support to Barn (2008) and Manthorpe et al. (2009) by identifying an under-representation of minority ethnic service users in residential care services but found that figures for community service use were similar to the White British population. Reasons for the under-representation within residential settings related to practical issues such as lack of purifying/washing facilities, poor understanding of dietary needs and an overarching perception of services as ethnocentric. Interestingly these researchers describe that even when figures were representative for receipt of services, minority ethnic service users reported being less satisfied and having a higher level of unmet need than the white population.

Three papers identify general practitioners (GPs) as a specific source of poor cultural understanding and differential treatment. Both Barn (2008) (referring to mental health) and Merrell et al. (2005) (in relation to carers) describe GPs as more likely to prescribe medication for individuals from minority ethnic groups than their white counterparts. Minority ethnic participants in both studies felt that medication was prioritised over counselling or psychotherapy and stated that they weren't referred on to other organisations for support. This finding is echoed by Manthorpe et al. (2009) who's work with professionals described the role of GPs as referring agencies as 'completely missing', stating that they 'do not relate to this group' (pg. 77). Merrell et al. (2005) identify a missed opportunity at GP surgeries to disseminate helpful information about support services to the minority ethnic communities. All three papers mentioned here were published prior to the introduction of the Care Act (2014) duties for health and social care services to integrate. The recent relocating of many social services professionals in GP surgeries and

health centres as a result of these duties may have encouraged an increase in sharing information between professionals and with the public, but this is not present in the literature.

The research in this theme indicates that lack of cultural understanding from a range of professionals could be responsible for the under-representation of minority ethnic people in receipt of health and social care services. Service users and practitioners acknowledge there are challenges in engaging with each other, and that the current system is not achieving satisfactory results. Forbat (2004) describes the health and social care system itself as based on discriminatory policies and practice and understands challenging this as the responsibility of all that work within it. This is particularly poignant when observing the reports of GP practice.

3.7.7 Training

Four of the papers considered training as an important factor for working with minority ethnic service users (3,8, 13, 18). As discussed in previous themes, Gunaratnam (2008) outlines the dangers of an over-focus on achieving cultural knowledge, stating that these require a fixed understanding of culture. Referring to these as 'canonical narratives', this researcher believes that focussing on these fixed positions is achieved at the detriment of providing person centred and individualised support. Willis et al. (2016a) explore this understanding further in their research with practitioners, where current training is described as insufficient. In this paper two different approaches to training are identified; primarily the 'fact-file' approach warned against by Gunaratnam (2008) which appeared to be favoured by practitioners, who wanted concrete explanations of cultural practices presented by members of the relevant culture to ensure legitimacy. This expectation is strongly challenged in literature as it not only requires an essentialist perspective of culture but also fails to recognise diversity within ethnic groups. This challenge of representation is also raised by one minority ethnic practitioner in the research. The second approach to training is described as awareness raising, and includes practitioners reflecting on their own beliefs and assumptions in order to better understand the impact of their judgments in practice. Willis et al. (2016a) propose the term 'cultural reflexivity' to replace cultural competence, in order to address and adapt the expectations of a fact-file approach to

training. They suggest that this be undertaken in conjunction with promoting person-centred working, to encourage practitioner confidence in working with individuals with different cultural beliefs.

There is some support for this person-centred approach in Manthorpe et al.'s (2012) research with practitioners, where training and skills development was found to be limited. Examples of good practice, where professionals had worked in a person-centred manner are presented in this paper, however, are described as uncommon. Practitioners described some training being provided in the form of distance learning, work books and group sessions, however this alludes to the 'fact-file' approach described above. Instead the participants involved in this research wanted training to include a consideration of the local context, with person-centred work being promoted in supervision and through mentoring. This expectation from practitioners indicates that they held flexible beliefs about cultural competence, more in line with the 'cultural reflexivity' proposed by Willis et al. (2016a).

It is fitting here to consider the results from Mold et al.'s (2005) literature review, where reviewers found that in the absence of cultural understanding, a 'one size fits all' approach had been adopted in residential care settings, adding to existing anxieties for minority ethnic older people. In papers where cultural competence was being addressed, this was in the form of 'cultural awareness days', and the 'need to develop professional ethnic diversity training' was acknowledged (2005:109).

Given the number of papers that identify cultural competence as an issue, it is unusual that there is limited evidence available that explores training needs specifically. The papers that do indicate that practitioner training is required presents a contrast between what researchers and practitioners feel is required. Researchers promote the requirement for individualised approaches that acknowledge the diverse, personal and fluid relationship between individuals and their cultural needs, whereas professionals seek the security of fact-based cultural knowledge.

3.7.8 Racism

The subject of racism was discussed in eleven of the papers (5, 10, 11, 12, 15, 18, 19, 20, 21, 24, 25) and as such is the largest theme. The variety of publications that included

reference to racism meant that they present a more coherent picture if subdivided into the separate sub-themes below.

3.7.8.1 Institutional/organisational Racism

Four papers refer to institutional or organisational racism. Forbat (2004) understands this as a 'fusion of abuse and institutional racism', referring to specific health and social care policies as disproportionately affecting the minority ethnic population. The author describes the impact of institutionally racist and abusive policies as cultivating an environment in which, through co-constructed experiences, service users feel that racism is directly related to provision of care and support. The participants in Forbat's research are service users with dementia and their carers but Beattie et al. (2005) identifies a similar theme in their work with practitioners; These researchers interviewed practitioners from both mainstream and specialist Black and minority ethnic service providers. They found that professionals from the BME services had a mistrust of mainstream services, particularly general practitioners, based on the belief that these services were racist. In support of these beliefs, practitioners identified the over-representation of Black males in the criminal justice and mental health systems, applying well publicised national examples to their local context.

Burr (2002) lends support to the participants in Beattie et al.'s (2005) study. In her interviews with mental health practitioners she identified that entrenched stereotypes about South Asian women as oppressed by a patriarchal system shaped the perspectives of professionals. These assumptions had been made real within the context of mental health service delivery and had an impact on the diagnosis and care pathways offered to these women.

Forbat, Beattie et al. and Burr describe the impact of organisational racism on users of health and social care services, but they are not alone in experiencing this discrimination. Goldstein (2002) describes the impact of the discriminatory employment practice that saw minority ethnic care workers employed to provide advocacy and promote the rights of minority ethnic service users. She describes the stress that this pressure brought, contributing to negative working environments for these workers.

Each of the four papers described above were published before the introduction of the Equality Act (2010) and The Care Act (2014), which bestow equality duties onto local authorities so there is potential for change to have occurred since their publication.

3.7.8.2 Greater Funding Cuts

Four papers extend the theme of organisational racism to specify that the application of funding cuts detrimentally affected minority ethnic service users more than their White British counterparts, leading to a reduction in the choice of support available for this group.

Lipman (2015) interviewed representatives of twelve different provider services, including specific minority ethnic and mainstream provisions. Her analysis identified that specialist services had experienced more funding cuts as a result of austerity measures but also that mainstream services had reduced their specialist services, leading to a twofold impact on the choices available to minority ethnic service users. Mold et al. (2005) also found a lack of tailored services available in residential settings and Beattie et al. (2005) describe the absence of specialist services for minority ethnic people with dementia. The latter described a service-led mentality leading to the provision of inappropriate support, concluding that more specialised services were required due to a mistrust of mainstream services based on perceptions of racist treatment.

Manthorpe et al. (2009) found similar results when considering the effectiveness of consulting with older people from minority ethnic backgrounds. Older people described the consultation process as tokenistic, with budgets constraining funding for interpreters, dietary requirements and transport to events. In combination these papers indicate that not only are current provisions to BME services being reduced, leading to inappropriate support, but that the failure to adequately engage with these groups in consultation processes means that their opinions are likely to be absent from the planning of future services.

3.7.8.3 Poor information and lack of awareness

For three papers the quality of information was perceived as a challenge for minority ethnic people. Reflective of Forbat's description of institutional racism, the provision of inappropriate or insufficient information can disadvantage minority ethnic individuals who

are trying to understand the health and social care system. This is a problem described by Manthorpe et al. (2009), with the participants in this study explaining that translated leaflets alone were not helpful for disseminating information as they often lacked the context that made information relevant and appropriate. These findings resonate with those of Alam et al. (2005) who identified that individuals with visual impairments preferred conversations over translated material when receiving information about services.

In their interviews with Bangladeshi informal carers, Merrell et al. (2005) found that participants lacked knowledge of what support was available to them and also experienced confusion about the differing roles of health and social care professionals. Moreover, because the majority of carers were found to be women, this study identified a gendered dimension to the poor quality of information provided.

3.7.8.4 Stigma and the expectation of racism

Four articles referenced an assumption of differential treatment based on ethnicity, with two referring specifically to stigma as an issue for participants. These two articles recognised the importance of acknowledging stigma in relation to mental health practice, Barn (2008) interviewed Bangladeshi social workers, who identified that for some of the minority ethnic service users they worked with, mental health was seen as shameful, explaining that ‘the women failed to admit an emotional need but were comfortable in describing physical symptoms’ (2008:76). The workers in this study accommodated this preference for physical health terminology and this enabled them to identify mental health needs. This approach was also applied by Mathorpe et al. (2010) in relation to well-being. Practitioners found that using terms such as well-being rather than ‘mental health’ or ‘mental illness’ on promotional material was more successful when encouraging people to access services, managing to ‘avoid alarm and putting them off using particular services’ (2010:36).

Additional to feelings of shame, two papers recognised that participants expected to receive racist treatment from service providers. Alam et al. (2005) located participant’s expectations in the experiences of racism they faced in everyday life, stating that these

racist incidents were generalised into assumptions about services. Forbat (2004) also outlines the importance of racist incidents in shaping expectations. She describes 'unwitting and unintentional' racism as responsible for creating an environment where interactions were interpreted as racist. For this author, the power imbalance in relation to ethnicity and disability generates a narrative of discrimination which needs analysing more closely in order to inform practitioners and facilitate change.

It is evident that racism in relation to services is multifaceted, with entrenched institutional racism impacting on the appropriateness of information, suitability of support and availability of funding for minority ethnic provision. In turn this develops an environment where existing stigma is reinforced by stereotypical assumptions about certain groups, and minority ethnic people expect to receive discriminatory treatment.

3.7.9 Cultural expectations of care giving

Finally, four articles explore the cultural expectations of care giving in relation to minority ethnic people (4,14,15,21). As described in previous themes Forbat (2004) recounts the discriminatory nature of health and social care policy, specifically previous legislation relating to informal carers. The Carers (recognition and services) Act (1995) is now revoked by The Care Act (2014), section 10 of which describes duties to carers, including entitlement to separate assessment independent of the cared for person, however Forbat's initial criticism remains relevant. The Care Act (2014) describes the requirement for a carers assessment to consider 'willingness to continue to care' (S10(5)) but doesn't require consideration of the influence cultural or familial expectations have in coming to this decision.

Greenwood et al. (2016) emphasise the importance of cultural expectations in their research with carers for stroke patients. The participants were from five different ethnic backgrounds and all believed that they, as family members were best placed to care for their relatives, however the South Asian participants also located their role in a context of cultural duty. Considering Merrell et al.'s (2006) research that indicated most minority ethnic carers were women, one can identify both the ethnic and gendered nature of this cultural expectation.

Further to Greenwood et al. (2016) and Merrell et al. (2006), Hoong-Sin (2006) interviewed White British and Indian Asian older people about their expectations of family and formal care provision. This study reinforces the existence of gendered and ethnic divisions in expectation, with the Indian Asian group proposing family as the expected source of care more frequently than the White British group. However, across both ethnic groups, a higher proportion of women expected their family to provide care, with males considering the state as able to support them.

Atkin and Chattoo (2007) add to this complex picture by outlining the sensitive nature of intervening in child protection cases. Although this research relates to social work with children, the participants were family members and professionals alongside young people themselves and the findings are generalisable and worthy of mention here. The researchers described the difficulty in child protection work with minority ethnic families as related to complex understandings of when professional involvement was necessary. For these families, there appeared to be a different threshold for when children's behaviour required involvement from services, and that this caused friction and required sensitivity to extended family and kinship relationships. This indicates that cultural expectations of both professionals and minority ethnic families themselves need to be considered and explored in order to avoid stereotyping or disadvantaging specific ethnic groups.

3.7.10 Relationships

Only two articles made specific reference to the importance of relationships in providing care and support (1,4), this is interesting given the recent policy and practice focus on providing person centred care within social work and social care. Larkin et al. (2018) describe the positive impact that good quality personalised relationships can have for minority ethnic individuals with learning disabilities. The researchers identify that service users evaluated the quality of their care primarily on the relationships they had with specific workers, with continuity and reliability seen as crucial to being classified as a good carer. Additionally, it was considered that when good relationships were built, service users were able to make complex context dependent decisions about their ethnic identity.

Similarly, Pound and Greenwood (2016) found that relationships, including communication and rapport were important in supporting stroke patients and their carers, with one participant describing the importance of being able to 'connect with someone' (2016:1992). This was seen as a universal requirement for successful care provision, however forming this relationship was described as more complex and time-consuming where there was a language barrier, particularly where the patient had high levels of need.

The researchers use the term 'humanly sensitive' care to describe ideal care provision. Based on a framework for humanising care (Todres et al. 2009). Pound and Greenwood suggest that applying the eight-point framework which includes attributes such as togetherness and personal journey to practice can help to ensure high quality care provision even where there are communication difficulties.

3.8 Conclusion

Despite the Department of Health report being published 20 years ago, evidence from the literature review suggests that although efforts have been made to address inequality, there is still substantial evidence of differential experiences based on ethnicity. The steps that have been taken, for example introducing cultural competence training, appear to have focussed on 'learning about differences' which has, in turn, created new challenges. Evidence from practitioners, service users and carers all indicate that even when difficulties are shared with the white population, these are exacerbated by issues that are specific to the minority ethnic population, for example language barriers and interpreter requirements. In addition, these specific issues are not felt equally across the whole minority ethnic population, for example second language acquisition is related to both age and gender.

4. Theoretical Perspectives

4.1 Introduction

This chapter describes the theoretical perspectives that underpin this research project. They are presented here in relation to the project to explain why specific methods, explored in the following chapter, are used, and why they are appropriate to the aims of the study.

4.2 Social Construction

I understand identity as a social activity, which can be situated within the theoretical framework of social construction. This is an umbrella term which encompasses explanations of society that come from the perspective that our world is not a fixed, external entity that we as individuals passively experience, but a world where reality is generated and perpetuated by our interactions. Burr (2003:3-5) describes social constructionism as without a single definition but as underpinned by four central tenets;

1. 'A critical stance towards taken for granted knowledge'; here Burr is calling for readers to think about the divisions and categories we use to make sense of our surroundings. She urges us to challenge the rigidity of these categories to better understand how they have come to exist. For this thesis, the decision to recruit older Pakistani women from a specific geographical area of England uses many socially constructed divisions; age, ethnicity, gender, and class.
2. 'Historical and cultural specificity'; by recognising that the categories and divisions within and between societies are fluid and unfixed between time, space, and place, we are able to consider what purpose they serve. In relation to this research project, how an older Pakistani woman experiences her life depends greatly on where she lives, her income, the political context alongside many other variables.
3. 'knowledge is sustained by social processes'; the categorisations that exist are perpetuated by the passing on of constructed ideas between people through their interactions.

4. 'Knowledge and social action go together'; the way we, as societies understand the world and the categorisations we create within it has an impact on our responses to those who fall within such categories.

It is clear from Burr's four tenets that social construction is heavily influenced by both interpretivist and critical theorist perspectives on the nature of reality. For the latter, this is underpinned by the acknowledgment of the impact of power. By understanding reality as socially constructed by our own interactions rather than an objective world awaiting discovery, we must also understand the influence that power can have on which divisions and categories are created, and how they are maintained. Burr (2002) refers to such constructed bodies of thought as 'discourses', which are created and maintained by those in positions of power, to ensure their position is upheld within a hierarchical society. Goffman (1963) on the other hand focussed more specifically on the creation and maintenance of specific groups as 'stigmatised' and explored the impact of such labelling on the behaviours of the group and the individuals within it. Both Burr's and Goffman's work is grounded in social constructionist epistemology.

4.3 Social Identity

Once we understand our reality as socially constructed, we can then consider the impact this has on the formation of identity. If the world as we know it, including the divisions and categories we use to group people together is created by our interactions, then this also has consequences for how we understand ourselves, and the behaviours that we, and the people around us, display.

In his 2014 work, Richard Jenkins presents a holistic approach to understanding social identity. Jenkins believes this concept is a more complex and interactional entity than the oppositional binary understandings often presented (internal v's external, similarity v's difference, individual v's group). His analysis starts with the premise that all identity is social, this is a belief shared by Goffman and myself. This understanding opens the wider debate around 'nature v's nurture' however here is not the place to expand on that

argument. The following section will focus on specific elements of social identity, discussing how they relate to the research project, participants, and their situation (more specific analysis of the impact of social identity on the participants can be found in the discussion chapter).

4.3.1 Aspects of social Identity

4.3.1.1 Identity as political and hierarchical

As discussed above, if the way we construct our world, and our identity is through interaction with others, then the issue of power is inescapable. Those with more power can manipulate the positions of themselves and others in society. For the participants in the research project, the implications of this can be understood in relation to any of the demographic categories in which they find themselves defined. Here I will discuss 'race' and ethnicity;

The social constructionist perspective acknowledges that racial categories do not exist outside of our creation and perpetuation of them. This is not to say that these categories do not affect people defined by them, quite the opposite. Malik (1996) suggests that it is an attempt by the powerful to justify inequality in society that perpetuates the idea of racial difference, rather than actual racial differences leading to inequalities. This would mean that the inequality experienced by different ethnicities is not a product of difference but is actually a discourse that is purposely maintained to elevate the position of one group at the cost of others. This is a position supported by Dyer's (1997) exploration of white privilege '*White*', in which the author identifies the fluid nature of 'whiteness' as changing dependent on who 'white people decide is white' (1997:45). These two arguments in combination demonstrate that those in positions of power, and those who share their characteristics are able to decide both who is, and who isn't considered their equal. Here the relationship to Burr's social constructionist tenets is explicit; racial and ethnic classifications are fluid, but this fluidity is 'rarely neutral' as Jenkins (2014) observes.

For non-English speaking older women, who are Muslim and originally from Pakistan, living in a deprived part of a post-industrial town in the north west of England, where there have

been significant tensions between the white British and South Asian populations in recent history, the impact of these categorisations on their identity is substantial. Gunaratnam (2003:12) recognises the significant political influence on categorisation stating that 'racial and ethnic categories are neither 'neutral' nor 'natural' but are socially and historically produced and are 'heavy with political meaning'.

4.3.1.2 Internal and external dialectic

Jenkins considers how identity is formed in relation to two opposing arguments; the first of which is the idea that we have an internal understanding of our 'self' that we present as our identity to others (the external). Secondly is the idea that we develop an internal understanding of our 'self' based on the responses we experience from others. Jenkins believes these processes to be simultaneous and interacting.

Mead (1934) understood this 'dialectic of identification' as the simultaneous synthesis of internal and external definition (Mead 1934 cited in Jenkins 2014:42); between the 'I' or internal self, and the 'me', or the self that is presented to others. This understanding requires the notion of self to be socially constructed; developing and updating in interaction with the external world. It is this interaction that informed Goffman's Presentation of Self, which progressed the idea to explore how, once we are aware of the 'officially accredited values of the society' (1959:46) we can utilise this knowledge to present a suitable performance.

For social identity theorists such as Mead, the process of identity formation begins in infancy, where primary identifications are learned and internalised to shape our understanding of ourselves. Mead, along with Jenkins and Goffman include gender as a primary identifier. It is acknowledged that although the components of gender are not consistent across time, space or place, the fact that gender exists as a binary category has not been challenged until relatively recently (for example Butler 1990). For the female research participants, they have no doubt that they are women, but what that means to them may be different dependent on the setting. Jenkins recognises 'kinship and ethnicity'

as a potential primary identifier, although includes the caveat that this is not universal and varies across circumstance.

I would suggest, that given the context of the women in the research study, that their ethnic identity is a primary identifier. If we consider the divided communities of the project's location and accept that identity is developed in interaction with others; the geographical division, along with the gendered nature of the unrest between communities in recent history would undoubtedly have an impact on the participant's self-identity. In Mead's terms, the participants would internalise and update their concept of self, based on their interpretation of the external reaction to them. Interestingly Jenkins suggests that 'identities that are established during infancy and childhood may be more robust and less flexible than identities that are acquired subsequently' (2014:84). This has implications for the identity of the participants, who all migrated to England as young adults, with identities in relation to their ethnicity, gender and other primary identifiers had been well established. From this perspective, the passion with which the women spoke of occasions when they had been racially abused can be understood as an attack on their primary identities. Their identity as women may also have encountered challenges, in terms of what this means in England compared to Pakistan. Here we can also see how Goffman's concept of stigma can be developed in the internalisation of the reactions of others to our 'self'.

Jenkins challenges Mead's work on identity for his reliance on a functionalist understanding of society, where society is 'non-complex', and that there are commonalities in what is expected of individuals across multiple interactions. For example; that our understanding of gender roles will be developed through consistent expectations of male/female division across interactions with others. Although for most, in our infancy this may be true of our care givers expectations, Jenkins believes that this explanation fails to recognise the impact of power and difference. Although Goffman's work does avoid directly addressing issues of power and hierarchy, he does acknowledge that different 'fronts' are required to present an appropriate and situation specific 'self'. Goffman focusses more closely on micro-level interactions and uses the idea of identifying 'officially accredited values' via 'sign equipment' as social cues to help us develop such an identity.

There is of course, another relationship affected by the internal-external dialectic of self-identity; the relationship between myself as a researcher and the participants. Cooley (1962:4) recognises that 'everything that I say or think is influenced by what others have said or thought and in one way or another, sends out an influence of its own in turn'. This complex cycle explains the interaction between the participants' influence on the researcher and the researchers' impact on the participants. The idea that the researcher is as much a part of the outcomes of research as the participant is part of the broader philosophy of both interpretivism and critical theory, with the latter acknowledging the impact of notions of power and hierarchy. This is an issue explored by Gunaratnam in her analysis of race of interviewer effects (RIE) on research. Gunaratnam concludes that such effects are not supported, due to the inability to control all variables other than 'race'. She also purports that to prioritise the effects of race over other categorisations imputes homogeneity where this does not exist.

4.3.1.3 Group and individual identity as related

As the above discussion reflects, the idea that a simultaneous process of internalising and presenting a 'self' does not just affect each person as a separate individual, it also affects our sense of belonging and group identity. The social constructionist epistemology understands categorisation as created and perpetuated by our interactions. A critical realist approach can be seen as a variation of this understanding which accepts that an external reality does exist. Critical realists (e.g. Bhaskar 1975; Lopez and Potter 2001) believe this reality however, cannot be known completely, outside of our interpretations, which are limited by the impact of socially constructed categorisations. Critical theory then pertains that these categorisations are maintained by those in positions of power, to secure their positions. Rather than attempting to separate explanations for individual and group identity formation, Mead, Goffman and Jenkins consider these processes to be closely linked as both are developed through interaction.

When discussing group identity, it is important to recognise that definition of what a 'group' means can have implications for whether we believe them to exist or not. Jenkins (2014) identifies minimal inclusion criteria for a group as; 'it's members know that it exists

and that they belong to it'. A more complex definition, one that includes reference to the homogeneity of members, will have consequences for which collectives can be distinguished as a group. A clear example of this could be the participants of the research project; I have so far referred to them as a group, however each individual did not know which other members of their luncheon club had volunteered to participate, unless they had shared this information themselves. Therefore, the participants did not constitute a group by these minimum criteria. The luncheon club members did however, know themselves to be part of the club, therefore the wider collective is part of a 'group'. They also knew, as such a group, that they all fit the criteria to participate in the project, once they were informed of this, and therefore, by their membership of the 'luncheon club' group, they automatically became part of a new 'potential participant' group.

Jenkins (2014) uses the term 'group' to recognise the members' self-definition and uses a 'category' to define a collective labelled only by external definition. Goffman (1958) presents this distinction by way of describing group members working together to preserve the 'front' from various 'others'.

This idea of developing as a group in interaction with 'others' requires further exploration here; Social identity theorists recognise both individual and collective identity as a process that develops in interaction, however Jenkins distinguishes between the two by way of emphasis. He believes the former to be associated with difference, and the latter with similarity, meaning that groups develop because of the similarities between themselves and other members. This position is further complicated when we consider whether our similarity to others draws us to the group, or whether being perceived as a member of a group draws out our similarities.

Goffman's (1959) work would indicate that we are able to recognise the external expectations of us as individuals and groups, and that we go to significant lengths to maintain our performance as a 'group member'. He also introduces the idea of a spectrum of consciousness in relation to these performances, moving from those involved having full consciousness of their 'performance' to acting with no recognition of the 'act'. In *Stigma* (1963:138), Goffman again asserts that the relationship between the individual and the group has implications for his individual identity; 'the nature of an individual, as he himself

and we impute it to him, is generated by the nature of his group affiliations'. Here Goffman also identifies the strategies that a stigmatised individual may employ both within the group of 'persons who are likely to have to suffer the same deprivations as he suffers because of having the same stigma' (1963:137) and between the 'stigmatised' and the 'normals'.

Barth (1969) along with Mead, Goffman, Jenkins and to some extent Gunaratnam and Malik, identifies the role of boundaries as fundamental to the formation of collective identity. For Barth ethnic collectives take on a construction of their own, independent of the individuals defined within their terms. This collective construction then generates similarity between members. The parallel is evident here between Barth and Gunaratnam and Malik, who both consider the homogenising of individuals from similar ethnic backgrounds as problematic, unrepresentative, and encouraging the elevation of racial difference above all other divisions.

Barth evidences his claim that groups exist and maintain external to their members by recognising that individuals can change their identities, for example an individual could change gender, but gender groups are still maintained. Similarly, individuals can change their ethnic or religious identity, but these groups still exist. Gunaratnam (citing Knowles 1999:123) concedes that 'in Britain... there are ready worked narratives of collective suffering which some people use to make sense of what has happened to them individually' however guards against essentialising such narratives.

4.3.1.4 Community

If we take the idea that boundaries and borders influence our identity formation, both as groups and individuals, and if we recognise the impact of power in elevating the status of certain 'groups' over others, then we also need to explore briefly the importance of 'community'. As explained above, Barth (1969) believed that groups develop an identity of their own, external to that of the individuals within it. This group identity can be considered a 'community', or symbolic representation of the similarity of its members, rather than signifying *actual* similarities. These symbols can generate a sense of shared belonging, even

if they do not accurately represent the behaviour of the members. For example, for the women in the study, their 'community identity' was closely linked to their religious faith, as were many of the symbols of this including the food choice of the luncheon club planners, the division of male and female dining areas and clothing choice. Taking food choice as an example, the luncheon club provided a traditional curry as the meal on every occasion I attended the session, over an 18-month period, however on visiting several of the participants in their homes close to lunch time, all had 'western' foods prepared or visible.

The idea of community is important, as there are many occasions in the social policy arena when 'community leaders' are asked to speak on behalf of their 'community' (Malik 1996). The presumption here, particularly in relation to ethnicity, is that these individuals will have similar interests, understandings, and expectations to the other members. The results of this can vary but are united in their inability to meet their objectives. Gunaratnam (2003) is vehemently opposed to this position, as she believes this does not recognise individual difference and elevates the importance of one identifier over others, ignoring the importance of both individual difference and other categorisations and groups that individuals may belong to. Intersectionality theorists would also challenge this approach, with a specific focus on understanding the impact of competing oppressions.

4.3.1.5 The 'Treacherous Bind'

In her 2003 work, Gunaratnam compiles damning criticism of research that unquestioningly accepts reductionist and essentialist categories of 'race' and ethnicity, utilising many of the arguments described above to justify the complexities of identity. Instead the author proposes a more relational approach to identity, recognising the plurality of difference. The consequence of essentialism is that inequalities and oppression can be seen as distinct to one group, owned by them, rather than as a symptom of hierarchical power relations. For example, in relation to the research project, the under-representation of ethnic minority older people receiving support services can be seen as a problem, specific to the ethnic minority population. This explanation fails to recognise this under-representation as related to other under-represented groups, and as part of a broader issue of inequality

of service provision. Seeing the issue in isolation then adds to the construction of the group as not in need of services or requiring a specialist provision. In the case of ethnicity and service provision this then feeds the stereotypical perspective that the extended family will take care of their older members.

Radhakrishnan (1996) supports Gunaratnam's commitment to the acknowledgment of plurality, directing her concerns to research, and to the homogenising effect of essentialist categories in conducting studies. He refers to the challenge of accepting the need for researchers to adopt some way of categorising participants in order to gather evidence to create change, whilst also refuting the categorisation of individuals, as this reinforces the essentialism the same research is required to challenge.

'no sooner do we mention race than we are caught in a treacherous bind. To say race seems to imply that race is real; but it also means that differentiation by race is racist and unjustifiable on scientific, theoretical, moral and political grounds. We find ourselves in a classic Nietzschean double bind: Race has been the history of an untruth, of an untruth that unfortunately is our history...the challenge here is to generate, from such a past and a present, a future where race will have been put to rest forever' (Radhakrishnan 1996:81)

In order to traverse this 'treacherous bind' Gunaratnam proposes three methodological points that, if considered, can allow a 'more effective and ethical way' (2003:32) of conducting research that uses categorisation. These points are summarised and considered in relation to the research project below;

1. There are contradictions in the nature of researching ethnicity from a social constructionist position; whilst attempting to expose racism and racialised understandings, one is simultaneously trying to uncover the constructed and 'fictional' nature of such categories. In addition, any work undertaken with these intentions' risks reinforcing essentialist understandings of race and ethnicity, by the necessary inclusion of these terms in the research itself. Gunaratnam's own words explain the relationship between this thesis and point 1;

‘while there must be temporary moments of closure in the defining of racial and ethnic categories in order to do research, these points of closure must also be opened up again in the process of doing research and analysis’ (2003:34)

The ethnic category of Pakistani was temporarily closed in order to recruit participants for this thesis, but the process of analysis will enable an exploration of the many complex identities that these participants present, hence opening up the category in line with intersectional theories.

2. There needs to be acknowledgment and interrogation, rather than dismissal, of the resonance between the racialised assumptions of some research, and the lived experience of people from racial or ethnic groups.

In relation to this thesis, there are likely to be similarities between the participants’ experiences. From my own experiences as a social worker at the start of this thesis it was evident that ethnicity was a barrier to accessing intermediate care. Jenkins explains that this is because group identity develops through interaction with society, in this case a locality where ethnic categorisation holds particular meaning. This however is not to go unchallenged; Using intersectionality allows a consideration of the complex and multiple oppressions experienced by each participant. This then facilitates the understanding that although ethnicity may inform part of the participants’ experiences, it is not the whole picture.

3. There are still theoretical approaches and disciplines where exploration based on essentialist categorisations is privileged as a practical way of conducting research.

At the beginning of this thesis, the objectives were unintentionally rooted in essentialist beliefs about the homogeneity of individuals from specific ethnic groups. Although the ethnic similarity between the participants does go some way to explaining their experiences (see point 2) this simplistic approach must be replaced by methods of analysis that allow the spectrum of differential experiences to be explored. Dialogic performance analysis examines the transcripts of each participant’s narratives

individually, enabling each participant's individual story to be told. Only after each transcript has been analysed, are potential themes between them explored.

4.4 Bourdieu, Capital and Social Work

Bourdieu's work is relevant to this thesis, particularly his use of habitus, field and capital to explain social and cultural disadvantage, he describes his philosophical position as 'constructivist structuralism or structuralist constructivism' (1989:14). Despite the ontological difference, many features of Bourdieu's (1989) analysis are reflected in Jenkins' (2014) understanding of identity and in combination they offer a framework through which discrimination and intersectional oppression can be understood.

4.4.1 Habitus:

Bourdieu, like Jenkins, describes the development of understanding the world as a dialectic process. 'Habitus is both a system of schemes of production of practices and a system of perception and appreciation of practices' (Bourdieu 1989:19). Through this dialectic process individuals are socialised from childhood to mirror the social divisions they experience. Bourdieu understands this process to result in individuals developing 'habitus', a set of loose, unconscious guidelines about expectations of themselves and others, similar to Jenkins' description of group identity development. Although he does not believe these guidelines to be deterministic, Bourdieu believes power structures to be rooted in reality, opposing Jenkins' understanding of these as constructed entities. Despite the differences, both authors acknowledge the interactive process of developing an understanding of the world and our place within it.

4.4.2 Field:

Bourdieu presents the different arenas of social life as 'fields', described by Houston (2002: 157) as 'areas of social relationship that are characterised by power differentials amongst the actors that make them up'. Here the reference to individuals as actors resonates with Goffman's (1956) exploration of social life as a theatre where 'performances' are enacted on a 'stage', described in more detail below. The majority of Bourdieu's work focusses on education as the most unequal of 'fields' but also references the domains of social welfare and politics as fields where inequality is endemic.

4.4.3 Capital:

For Bourdieu the source of inequality is class division, which also acknowledges the importance of other attributes including gender, ethnicity and disability as impacting on the opportunities afforded to individuals and groups. The distribution of four different types of capital is the system through which advantage and disadvantage is maintained. Bourdieu divides capital into; economic capital – finances and possessions; cultural capital – recognised knowledge; social capital – connections and social ties; symbolic capital – perceived status. Possession of these different forms of capital enables some to capitalise on their assets and sustain or enhance their position, whereas those without this luxury experience disadvantage and discrimination.

4.4.4 Social Work

Houston (2002) proposes that social workers can use Bourdieu's theory in their work with service users. He encourages practitioners to reflect on their habitus, position in the field and possession of capital in order to prevent them contributing to the perpetuation of disadvantage. Two facets of reflection are outlined for practitioners however these are also applicable to researchers in the field of social work;

1. Reflecting on individual values and how these have developed based on experiences and knowledge of habitus, field and capital. This reflection then enables practitioners to identify how their identity has developed, and whether there are 'blind spots' as a result of these experiences. In social work research this is important when engaging with participants. Co-constructed narratives are developed in interaction between researchers and participants, so an understanding of and ability to address one's own value judgments is vital to providing an environment where participants feel able to share their experiences.
2. Achieving self-awareness then facilitates practitioners to consider how inequality in the field distorts perceptions. In the field of social welfare this relates to notions of deserving and undeserving, which are entrenched in policy and practice (for example Forbat's 2004 exploration of discriminatory legislation). There are over-representations of specific groups in some services and under-representations in

others, according to Houston these require exploration in order for social work practitioners to understand the impact of habitus, field and capital on the people they work with. Here social work researchers have a responsibility to uncover these inequalities and provide alternative models of practice.

Finally, Houston (2002) considers the role of Bourdieu's work in enabling the development of cultural sensitivity. This is described in four stages and differs significantly to the fact-file approaches identified in the literature review as a favourite of practitioners. The approach focusses on empathy as an 'accurate understanding of another person's cultural experience, emotions and behaviour' (2002:159). As narrative analyses such as dialogic performance analysis also seek to understand these elements, the process remains relevant to both social work practitioners and researchers alike.

1. Primarily Houston advocates a consideration of the person's experiences with fields, remembering that the fields of education, welfare and politics are where most inequality is located. This means that as people using services, those that practitioners work alongside are likely to have experienced inequality in these fields, either consciously or unconsciously. For participants in this study, these interactions with the field may include confusion, exclusion and discriminatory experiences.
2. Practitioners are then encouraged to reflect on how an individual's life events and childhood socialisations have affected their sense of self, others and the world they live in. Here Houston includes Bourdieu's understanding of life events and socialisation as impacting on the development of identity. Although Bourdieu believes interaction with social structures also has a role in shaping identity, there is similarity here with Jenkin's understanding of identity development as a dialectic process between the individual and the environment. Analysis of the interview transcripts of this thesis will enable me to uncover the nature of the participant's self-identity and consider the impact of different events and interactions.
3. The 'material aspects' of life are then explored, Bourdieu prioritises social class over other groupings such as gender and ethnicity, although these also require exploration. Here Bourdieu differs from Jenkins and Goffman, who believe a combination of 'group' identities can affect individual identity formation. Gunaratnam specifically challenges this prioritising of one characteristic at the detriment of exploring the intersectional

nature of disadvantage. Given the over-representation of minority ethnic people experiencing lack of capital (Khan and Shaheen 2017) it is important that intersectional oppression is explored at this stage in both practice and research.

4. Finally, in practice environments, social workers must explore with service users how to maximise or develop existing capital. To manage this task, there should be a focus on awareness raising in relation to structural disadvantage, whilst rejecting deterministic explanations and focussing on empowerment. In current practice, the move towards rights-based social work, and service-user involvement has enabled collectivised challenges to traditional notions of cultural capital, for example the requirements to include 'experts by experience' in social work education has developed a new form of cultural capital. Research can help arm practitioners with detailed knowledge required to raise awareness, particularly where analysis methods enable an analysis of meaning rather than taking data at face value.

4.4.5 Hysteresis

Although Bourdieu's primary focus is class, his work does encourage an exploration of other factors and proposes the term 'hysteresis' to describe situations where individuals experience a lag or mismatch between the habitus and significant rule changes in the field. Here the author encourages practitioners to focus on the impact this has on the individual and their ability to locate themselves within new power structures, where their existing capital may not hold the same worth. In this research project some participants had occupations that carried substantial capital prior to arriving in England, for example as teachers. The experience of reconciling this with their new status may have had an impact on self-identity, for example where qualifications were not transferable. Interestingly, within the same 'group' or community, some aspects of capital may still hold value, for example the symbolic capital that the profession carries, but other aspects may be lost, for example the economic capital associated with a professional salary.

Despite ontological differences between Bourdieu and other theorists discussed in this chapter, the concept of capital is important to understanding the impact of intersectional disadvantage on the participant's identity formation, and on their experiences of interacting with health and social care professionals.

4.5 Goffman and Social Identity

Jenkins, Gunaratnam and Bourdieu's work concentrates on the inequality and injustice of structural or socially constructed divisions, and the impact these have on the development and perpetuation of disadvantage for certain groups. Goffman, in comparison directs his attention to exploring the micro interactions between individuals. In his separate publications Goffman describes the nature of identity development as discussed below.

4.5.1 Stigma and Social Identity

Goffman's work can be better understood as part of the broader theoretical perspective described above where identity formation is seen as a social activity. Despite heavy criticism of his data collection methods, and reluctance to commit his own wholesale theory of social identity to publication (Smith 2006), Goffman's essays each individually support this philosophy.

Goffman's work in *Stigma* offers an explanation for social identity formation when the individual or group experience discrimination. Goffman describes stigma as;

‘an attribute that is deeply discrediting, but it should be seen that a language of relationship, not attributes is really needed, an attribute that stigmatises one type of possessor can confirm the usualness of another’ (1968:13)

Here he identifies the fluid nature of stigma and the stigmatised as situation dependent, presenting his work as a theory of social identity. In relation to the Pakistani women, during their early life in Pakistan, their ethnic identity as ‘stigmatised’ would not have existed in their everyday interactions with others, as most of these interactions would be with other Pakistani nationals, who spoke the same language. The stigma only presents itself in everyday interaction on their arrival in England, where their difference is visible in comparison with the majority white British population. This difference is present both in relation to physical characteristics such as skin colour and clothing choices, but also in relation to language and cultural norms.

In relation to this research project my initial thoughts focussed on using this theory to help explain the experiences of the women in relation to the stigmatisation of their ethnic origin

only, however the fact that all participants were women indicates that the relationship between this theory and gender is also of great significance, particularly considering the criticism levelled at Goffman's work from feminist theorists (discussed later). Throughout the project the importance of class in the women's experiences also emerged as significant. The assumptions I originally made in relation to ethnicity as a primary indicator of the women's identity is discussed below, as is the importance of analysing the intersecting oppressions that the participants faced, in order to better understand their experiences.

Goffman suggests that 'stigmatised' group members have more in common than not, and therefore should be studied together. This is an argument vehemently refuted by Gunaratnam (2003), who believes that the study of ethnic groups in isolation can present numerous challenges, including the conflation of similarity based on single indicators such as ethnicity, rather than considering the complexity of an individual's intersectional experience.

4.5.2 Goffman and The Presentation of Self in Everyday Life

In his seminal text *'The Presentation of the Self in Everyday Life'* (1959) Goffman describes the self in all interactions as a performance, with each performance located on a spectrum from sincere to cynical. Sincere performances are those that the performer believes to be their 'true self', where the performance elements of interaction are subconscious or a socialised norm/expectation. In opposition to this, cynical performances are those where the actor is aware of their behaviour and the way they present their 'self' to others in interaction. Irrespective of the sincerity of the performance, Goffman describes the objectives as goal orientated;

'...when an individual appears before others he will have many motives for trying to control the impression they receive of the situation.' (1959:26)

This understanding relates to Houston's description of individuals as 'motivated by a need for recognition' (Houston 2002:159), with both accepting a self-interested self who prioritises the progression of their own position.

In order to better understand how this relates to the research project, I have summarised some of Goffman's elements of performance and their relationship to the interviews

undertaken, this relationship will be examined more explicitly in the next chapters. Here I have chosen aspects of Goffman's theory that appear to relate most to my observations.

Goffman explores human interactions or 'performances' in order to explicate the elements that compose them. He believes these elements can be generalised and are recognisable in all interactions. Once established, Riessman (2008) furthers this theory of interaction by creating an analytical framework by which to understand the meaning of the performance. She identifies key features of speech and interaction that indicate increased significance. These features can be applied to interactions across the spectrum of sincere to cynical performances.

Goffman defines interaction as performed by means of a 'front' or stage. The 'front' includes several aspects including the setting (or place where the interaction takes place); the formal front, which includes the physical equipment that is required to set the scene; and the individual actors' manner. In combination, the control of these aspects allows individuals and groups to manage their presentation and ensure a positive impression, referred to as 'impression management'.

In relation to the research project there are two main settings, the Community Centre (CC), where I met the participants each week for the luncheon club. This setting is the same for each participant. The second setting is the participant's home, where the interviews took place, this setting is different for each individual. More broadly, the geographical area, both the immediate locality and the town itself can also be seen as part of the setting; the economic, cultural and political makeup of these has direct implications for the more specific settings. An example of the broader setting influencing the immediate setting is the physical state of the CC. The building is in need of repair and does not have adequate seating for some of the attendees who have physical disabilities. This can be understood as a result of austerity measures by the local authority, and also as a symbol of the lack of value placed on such preventative support systems (see chapter 2 for a more detailed discussion of the history of the geographical area).

Goffman asserts that in order for a front to be accepted there has to be a shared understanding of the 'accredited values of the society' (Goffman 1959:46). Examples of this at the Community Centre include the understanding that the men and women eat their

meal in separate rooms and that any children who attend sit with their female relatives. In the homes, this included escorting visitors (myself on the day of interview) into the front living room, or more formal living space if one was available, although this was not fixed and is explored further in relation to region behaviour.

The formal front or equipment required to uphold the front at the CC includes the food and shared understanding of how to eat each dish. For example, on one of my early visits to the centre I failed to realise that the rice dish was a pudding and was gently corrected by one of the women attendees. Goffman may explain the acceptance of my misunderstanding by the women as I am not seen as part of the 'front', however if one of the regular attendees had made this error it would have been interpreted as unusual and drawn more attention and questioning from the other patrons. The food in this example is part of the 'manner' of the women attendees; in order to maintain the front, there is a shared understanding of not only what order in which to eat the dishes but of how to eat them.

Another example includes the use of a face veil or niqab; some women chose to wear this item of clothing to the CC, however removed this once they were in the women's dining rooms. On occasion male patrons would enter the women's room but would usually knock as a sign of respect so that the women could cover their faces if they chose to. On one visit during hot weather, the door was propped open and a man entered the room on two occasions without knocking. During this event, I was sat opposite a woman who chose to cover her face and shared a joke about her frustration at this unannounced intrusion interrupting her meal time. This demonstrates that although I was not part of the front, as I began to get to know the women, and learn about their individual relationship with their culture and faith, I was accepted as able to share humour about the day to day challenges.

The shared understanding of manner can also be observed in both settings; at the PCC all women demonstrated gestures and behaviours that indicated they were interested in understanding my presence, however the ability to understand this was hampered by the lack of common language. Once this was explained by one of the members who spoke both Urdu and English, questions were asked and answered and as the weeks passed the women began to share their conversations with me, using the language skills that they did have. On many occasions, members tried to involve me in their conversations, by giving me short

explanations of the context; for example; following one woman's holiday to her family's home town in Pakistan she was discussing the problems with the electric supply to the more rural areas. The women joked about their memories of trying to cook for a large family in such conditions, and their relief at returning to England for this task. Seeing my struggle with understanding the conversation, the women explained this to me, presenting their front and allowing me access to their 'shared understanding'.

My interactions with the CC attendees at an individual level also present examples of manner helping to create and maintain the 'front'; when attending the women's homes to conduct the interviews, each woman referred to her friends at the centre, they reported on their friendships, their friend's health and how their families were connected. For example; through being in the local hospital together when giving birth to their children or living in connected villages as young women in Pakistan. On visiting each home, I was offered refreshments and enthusiastically encouraged to accept.

Goffman continues the metaphor of theatre to explain 'region behaviour' or the different spaces in which the 'front' is enacted. The 'back region' refers to the interaction between grouped individuals when the audience is not present, with the 'performance area' being the space in which interactions can be witnessed by an audience. The fronts of the research project can be explained by way of this metaphor; the CC luncheon club could be viewed as a traditionally back stage area until my attendance, where women from the local Pakistani community came together to socialise. My intrusion on this closed setting will have had an impact on the behaviour of the attendees, turning the luncheon club into a performance area. This can be seen in the reluctance of some of the women to ask why I was there, despite their obvious curiosity. This example also highlights the fluid and constructed nature of the concept of 'fronts', as these change over time and circumstance.

The women's homes are another example of my intrusion on a traditionally back stage area of their lives. The preference to direct me into the formal entertaining space of the home rather than the kitchen, where the women were often sat when I arrived, can also be explained by the reallocation of back stage and performance area. From the whole home being a backstage space, to the room assigned for the interview becoming a performance area in my presence. This border was controlled by a family member closing the door in several of the interviews and was emphasised on two out of the eight interviews conducted

in participant's homes by family members offering to show me around newly decorated rooms of their homes or pointing out pictures of their children's graduation photographs in the hall way.

The language barrier can be seen as a key contributor to the maintenance of the performance area; during the PCC luncheon club the members chat freely amongst themselves about aspects of their lives and families. My inability to speak Urdu, Punjabi or Gujarati meant that I was unable to understand these conversations and was dependent on the few women within the group with the language skills and confidence to interpret for me. On many of the occasions I attended there was no one present who was able to conduct this task, and I was keen not to place pressure on the few members of the group who could help on the times that they were present. As a result, there were several attempts by both the members and myself to make ourselves understood, with varying degrees of success. Considering the amount of time spent there and the extent of conversation I was unable to understand, it is interesting to consider what information the members did choose to try and communicate to me. This filtering of information considered as appropriate to communicate can be seen as a barrier, allowing the club to become both back stage and performance area simultaneously, enabling the front to be maintained through lack of shared language. One example included an animated discussion between a small group who, on seeing my confusion attempted to explain their conversation.

Further to this understanding of language as a filter, Goffman's approach also lends itself to interpreting the use of language as a defensive attribute, by not enabling the translation conversations that betray the front. Goffman recognises that the relationship between performers and audience is not fixed and is changeable over time. As the performers become more familiar with the audience, they change their presentation, relaxing the front. It is important to understand this filtering through the spectrum of cynical to sincere performances; it is not assumed that the regulating of information is a conscious mechanism, rather a subconscious desire to present conversations believed to be of interest to the researcher. This process in itself is laden with subjectivity from the participants' expectations of my interests.

The example given above of the electrical supply in rural Pakistan compared to the UK could be understood as presenting a favourable opinion of the UK compared to Pakistan. Other early conversations included positive stories of how many of the women knew each other from their time on labour wards in the local hospital whilst having their children, of making their own clothing or of families being from the same village in Pakistan. All of these stories uphold a front of a close-knit, supportive community, often the way the Asian community is presented to the general UK population. Goffman's definition of 'defensive attributes' can explain the choice to translate these stories over more neutral or negative discussions between the members.

As predicted by Goffman, the nature of the stories changed as I became more familiar with group members and I was allowed access to more personal or humorous stories that could risk exposure of the front. These included a comical tale of one of the members who wore all her jewellery to the centre when she attended.

4.5.3 Critique

Goffman's work is not without challenge and is frequently criticised for a lack of theoretical substance, described by sociologist Smith as 'not theoretically ambitious' (Smith 2006:1). He is challenged for reliance on the description of a diverse set of examples drawn from life experiences rather than applying a theoretical framework to analyse or predict behaviour. The preference for eclectic examples over an explicit method of data collection leads Meltzer et al. (1975) and Coiffi (2000) to reduce Goffman's work into redefining common sense, dismissing it as unable to be replicated. Goffman himself acknowledges that his work is descriptive rather than analytical and refers to *The Presentation of Self in Everyday Life* as 'a set of features...which together provide a framework that can be applied to any concrete social establishment' (Goffman 1959:1).

Alongside the lack of defined data collection method, Goffman also resists presenting a wholesale theory of social interaction, appearing to dismiss 'grand narratives' in favour of analysing more intimate interactions. This avoidance of committing to a large-scale theoretical explanation of interaction in society means that the importance of structural oppression is not addressed to the extent of other theorists' explanations, such as

Bourdieu. Here Goffman appears to receive criticism for not achieving an objective that he never proposed to begin with. Goffman does address the politicisation of the oppressed in his 1963 work, *Stigma* (Goffman 1963) however his explanations focus on the interpersonal and social aspects of stigma in individual and group responses to their imposed identity rather than the theorising of the structures themselves.

Recent attention has been directed to Goffman's work on stigma, influenced by sociologist Imogen Tyler, who suggests that a focus on the micro-social 'often side-lines questions about where stigma is produced, by whom and for what purposes' (Tyler and Slater 2018:721). For Tyler and colleagues, addressing stigmatisation requires a critical approach to its existence, pointing to the example of corrupt practices in health and social care where privatisation has meant multinational companies profit from the increased focus on specific forms of stigmatisation, manipulated by their involvement in campaigning.

Goffman again acknowledges the lack of theorisation in his work, however does not believe this to be a deficit; rather, he views his work as a precursor to others taking on the challenge of more rigorous investigation. Smith summarises this by stating that 'only uptake by other researchers will determine the utility of the concept for sociological inquiry' (Smith 2006:120). Riessman is one researcher who has taken up this challenge and has championed the use of dialogic performance analysis, where features of performance speech can be identified and analysed once transcribed from narrative interviews.

A further criticism of Goffman's complete works is the lack of continuity from one essay to the next; Goffman preferred to start each text as a new enterprise which lead to some repetition, according to Smith (2006:2) this 'irritates even those readers who appreciated the detail of his sociological labours'. Williams (1988) however, considers this from a different perspective, believing this to be a conscious decision in order to add credibility by building up a collection of essays all supporting his perspective, rather than one continuous theory being advanced in each paper.

Despite the accusations of lack of replicable methods or theoretical framework, it is exactly these qualities that make Goffman's work so appealing as an influence on this study. In combination with Bourdieu's use of habitus, field and capital to understand the power relationships within performances, Goffman's focus on the interpersonal can be located in

the wider contemporary context of discrimination. Including Jenkins' explanation of identity development and incorporating Gunaratnam's warnings against over-focusing on one characteristic enables me to understand, through analysis of the performance (Goffman), the impact of lack of capital (Bourdieu) on the participant's identity (Jenkins), whilst acknowledging the intersectional dimensions of this experience (Gunaratnam).

4.6 Feminist Research

4.6.1 Feminism and Goffman:

The theories described above can be utilised together to further our understanding of narrative exchanges or performances, and how these relate to the broader context of the health and social care field. However, Goffman is not only critiqued methodologically and theoretically, his work also faces challenges from feminist scholars particularly in relation to his use of masculine terms and gendered examples within his publications (West 1996). Despite this, West does discuss Goffman's influence on feminist research, warning against dismissing his contributions. Although not a key objective of his work, West believes Goffman's attention to the interpersonal, described as 'an appreciation of how power works in spoken interaction' (1996:360), particularly in the *Interaction Order* (1983) influenced many academics to apply this concept to gender relationships. Researchers used Goffman's principles to explore how genders are embodied in the roles and actions of conversational exchanges. For example, Zimmerman and West (1975) identified that men interrupted women 96% more than women did men and that these interruptions were characterised by a destruction of the conversation's coherence, meaning that women were unable to conduct conversations with the opposite gender unless the subject was appealing to them. Henley (1977) in addition, described women as more likely than men to provide support work within conversational exchanges, more actively demonstrating attention and displaying appreciation, whilst in contrast men implied a lack of interest in women's conversations.

These studies are of course dated however they demonstrate Goffman's relationship to feminist research. West suggests that his interest in exploring the interpersonal opened

the door for academics to explore the gendered nature of power relationships within conversational exchanges.

4.6.2 Reflecting on Feminism

Feminist research emerged as an attempt to increase the academic attention afforded to traditionally 'female' subjects, often referred to as bridging the distinction between the public versus personal, or between male and female domains. Described as 'liminal' by Ribbens and Edwards (1998:2), feminist research requires researchers to be situated on both sides of a metaphorical border, both in relation to the professional/personal balance necessitated in choosing appropriate research methods, but also in reference to the lived experiences that women share. In order to conduct research into the personal lives of participants, methods that facilitate and enable the sharing of sensitive information are advocated.

It is important here to restate that this research project did not begin with a conscious decision to take a feminist approach. The original aims were on reflection, grounded in homogenous assumptions about the participants, based on stereotypical views about their ethnicity and gender, albeit founded on practical experience and with the best of intentions. As an employee of a local authority social work team when this thesis started, the initial aims of the research reflected the pragmatic and organisational expectations of institutional systems. I can now understand the desire to find swift practical solutions to complex and multi-faceted challenges such as under-representation as limiting and unlikely to achieve real change for those in need of it.

What has remained consistent throughout this thesis has been a determination to retain each participant's narrative as a whole rather than fragmenting their words into themes until their individual voices were lost. The requirement that the women's stories were retained required a specific method of analysis such as dialogic performance analysis, the chosen approach for this thesis (explained in detail in chapter 5). I believe this method, when utilised in conjunction with an appreciation of intersectional disadvantage and Bourdieu's concept of capital can offer a greater understanding of the women's experiences and fits within a feminist paradigm.

Feminist research is an umbrella term, encompassing a multitude of different perspectives but this description by Bhavnani (1994), although not recent, corresponds with my aspirations for this thesis;

‘Any study whose main agent is a woman/women and which claims a feminist framework should not reproduce the researched in ways in which they are represented within dominant society – that is, the analysis cannot be complicit with dominant representations which re-inscribe inequality’ (1994:29)

Despite a desire to ensure that women’s voices are prioritised, and discriminatory representations are challenged, there are difficulties in enabling this in the practice of doing research. As Standing (1998) asserts ‘by the ways in which we write, and represent their words to an academic audience, we may in fact reinforce and contribute to the inequalities of power’ (Standing 1998:187 *in* Ribbens and Edwards). Here the author suggests that the academic vocabulary along with the process of transcribing and analysing the words of participants can perpetuate existing divisions. Standing then adds that a dilemma emerges between maintaining the accessibility of research at the risk that it will ‘not be taken seriously, seen as simple, untheoretical, not sufficiently academic’ (1998:186) or compromising authenticity in order to satisfy an academic audience. In her work, Standing is referring to reinforcing hierarchies of power in relation to class structures that prevent those from lower socio-economic groups from accessing the knowledge required to enter the academic world, but this could easily be transferred to any disadvantaged group.

4.7 Intersectionality

Intersectionality is an approach discussed by Kimberlé Crenshaw that acknowledges the differential experiences of individuals facing multiple forms of oppression and disadvantages. Originally published in 1989 to describe the specific nature of discrimination experienced by Black women, Crenshaw highlights the need to consider the multiple experiences of disadvantage that result from individual circumstances. Her work developed in recognition that feminist theory had not adequately acknowledged that gender disadvantage was not equally experienced by all women, and that those who simultaneously experienced discrimination because of their gender and ethnicity were at

an increased disadvantage. Crenshaw describes disadvantage as being conceptualised along a 'single categorical axis' (1989:140), a framework that requires Black women to choose whether to experience discrimination as gendered or ethnically motivated, but not both. According to the author, the result of this 'single axis' understanding of oppression is the erasure of Black women's experiences.

What Crenshaw is not proposing is that there is a hierarchy of oppressions, that labels and weights different characteristics, and adds them together to result in a quantitative system of ranking disadvantage. She describes that 'these problems of exclusion cannot be solved simply by including Black women within an already established analytical structure. Because the intersectional experience is greater than the sum of racism and sexism' (1989:140). In facing multiple forms of oppression, the disadvantage experienced takes on a form of its own, not to be compared to that of white women or Black men.

Crenshaw's challenge to existing feminist theory is reinforced by Judith Butler in her 2004 work; *Undoing Gender*.

Feminism ought to be careful not to idealize certain expressions of gender that, in turn, produce new forms of hierarchy and exclusion (2004:8)

Here Butler appears to be warning against privileging specific presentations of gender above others, as this results in delegitimizing and erasing the experiences of minorities, reflecting Crenshaw's desire to understand and embrace intersectional experiences in their own right.

Considering the above, it is important to acknowledge the relationship between intersectionality and this thesis. As a relatively young, able bodied, professional, white woman interviewing older Pakistani women, some of whom also lived with disabilities, I am in a position of privilege. According to Crenshaw, white feminists speaking on behalf of Black women both facilitates and exacerbates the challenges they face as the white experience functions as a norm, erasing that of Black women. It is therefore, fundamental to clarify that the methods chosen, and the theories discussed in this chapter, on which they are based, have been chosen specifically for their ability to present the stories of the participants, however, they are, and always will be, my interpretations of their stories. This is discussed in more detail in the next chapter, in relation to representation.

4.8 Conclusion

This chapter has explored the different theoretical frameworks that underpin the methods chosen for this thesis. Jenkins (2014) provides an explanation for the development of social identity by advancing theories from the body of existing research in the field of identity work. Goffman's understanding of social interactions as performances helps us to explain the interpersonal nature of the narratives but doesn't alone provide a thorough account of the impact power has on the relationships involved. Bourdieu offers a theory that enables us to understand the hierarchical nature of interactions based on possession of capital. Despite different philosophical positions, this understanding of power distribution can help us to explain the participant's differing experiences. The notion of capital relates directly to Crenshaw's identification of intersectionality; although different characteristics such as gender and ethnicity are not types of capital themselves, there is a relationship between distribution of capital and these (and other) characteristics. The distribution of capital is not equal and reflects societal oppression and discrimination. Therefore, those experiencing the most substantial intersectional oppression are likely to also possess the least capital in order to change their situation. The impact of the relationship between the two is played out in the narratives of this thesis, where participants each face a spectrum of inequalities relating to their ethnicity, gender, socio-economic position, health and age.

5. Methodology

5.1 Introduction

In order to decide on methods of research and analysis, it is important to consider the researcher's ontological and epistemological beliefs, along with the aims of the research, to ensure continuity and appropriateness.

5.1.1 Ontology

Ontology is described as 'the science or study of being' (D'Cruz and Jones 2014) and is concerned with the nature of reality. McLaughlin (2012) identifies two opposite ontological belief systems between which a spectrum of positions are arranged. Realism is the belief that 'there is an external reality that exists independently of our views or understanding about it' (2012:25) whereas idealism is the understanding that 'reality is only knowable through the human mind and through socially constructed meanings' (2012:26).

This thesis includes the exploration of concepts such as ethnicity, gender and social class in relation to health and social care. Considering how each ontological position would understand these categorisations can help to identify which is more suited to the aims. From a realist perspective, categorisations would be 'real' and therefore fixed, whereas from an idealist position these demographic divisions are constructed, and do not exist outside of our belief in them. This study considers the differential experiences of participants with similar demographic indicators and includes the significance of factors such as local history, relationship to the interviewer and the impact of previous experiences. Therefore, a fixed position such as that offered by a realist ontology would not be appropriate to explain these. Similarly, understanding each person's position as unique and constructed entirely individually, as an idealist perspective would, denies the continuities of experience between the participants based on categorical similarities.

A plethora of different ontological perspectives fit on the spectrum between idealist and realist, for example critical realism and relativism. Social construction also fits here as an idealist position influenced by aspects of realism. Described in the previous chapter, this approach understands our experiences of the world to be constructed by our interactions

with the environment, and with other people, therefore enabling the development of shared understandings.

5.1.2 Epistemology

This ontological position influences epistemological decisions. Epistemology is concerned with 'what we can know about reality' and how we can acquire knowledge (Willis 2007), therefore the epistemological approach to any research is heavily influenced by the researcher's ontological perspective.

Kuhn (1970) originally developed the idea of different research 'paradigms', organised based on ontological and epistemological beliefs. Willis (2007) suggests that there are three main research paradigms; post-positivism, interpretivism and critical theory. In order to fully explore my own choices, it is necessary to start with an understanding of these, below is a brief, simplified definition each, adapted from Willis (2007).

Post-positivism – derived from a realist ontological perspective, this is the idea that an external, factual reality does exist, and can be identified, researched, studied and ultimately known objectively using scientific methods. This approach evolved from positivism, and acknowledges that there are differing perspectives on reality, but that these biases can be addressed by controlling variables to achieve objectivity. Additionally, in comparison to positivism, post-positivism does recognise the usefulness of some qualitative research methods.

Interpretivism - the belief that irrespective of whether an external reality may or may not exist, there is no way of humans can know this reality objectively because our environmental and social interactions influence our understanding. Researchers influence their research subjects (either living or inanimate) by their very existence as constructed beings. Researchers *interpret* their data just as individuals interpret the world around them.

Critical theory - premised on the idea that oppression and hierarchy exist within the world, whether it be constructed or real, and that by researching and making such oppression known, researchers can expose and undermine this, using their findings to challenge injustice. In social work this has evolved to include emancipatory research and a

perspective defined as critical social work, which engages with people experiencing disadvantage, in order to empower and advocate for their rights.

5.2 This thesis – feminist research

This research explores the experiences and opinions of Pakistani older women in relation to their experiences with health and social care services in England. As such one could expect that, informed by existing knowledge of oppression and disadvantage from the literature review, using critical theory as a research paradigm, would facilitate exploration of this. Although this may be the case, there are also exploratory components to this thesis; as the literature review highlights, there is very little research that considers older minority ethnic women's experiences of health and social care, particularly those without English language skills, therefore interpretivist perspectives enable an exploration of these perspectives and can prevent deterministic presumptions.

Feminist research, like feminism itself, is an umbrella term that encompasses many approaches, some of which stem from interpretivism, and others from critical theory. Hughes (2002) summarises the schemas of two feminist authors who have attempted to distinguish between different feminist positions. Evans' (1995) conceptual schema of difference (2002:59) describes three approaches;

1. Woman-centred feminism – prioritises the differences between men and women, acknowledging both as equals and rejecting all paternalistic institutions and creations, retaining a commonality between women.
2. Identity politics – recognises intra-group differences between women and charges traditional woman-centred feminism with privileging the views of white middle class women. Intersectionality as understood by Crenshaw (1989) lies in this category.
3. Post-structural – all identities, including gender, are rejected in favour of valuing unique individual experiences and forms, with each being accepted as equally valid (the work of Judith Butler can be understood under this definition).

Whilst locating perspectives within a schema helps to understand their key messages, Evans herself acknowledges that categorisation can be restrictive, and that feminist researchers can and do utilise a combination of approaches within their work. Therefore,

although this thesis utilises an intersectional approach to feminist research, this is not used as a 'strait-jacketed position' (Hughes 2002:62).

5.2.1 Doing feminist research

Having identified the differing feminist perspectives, Harding (1987) outlines different ways of including women in research, dividing these based on their usefulness to women. She believes that additive approaches, where the opinions of women are added to outcomes of existing male dominated research, are unhelpful, as are approaches that consider women's contributions to existing domains. These ways of researching women's experiences are still seen as guided by patriarchal discourses where men choose what is researched and set the norm for outcomes to use as a benchmark for comparisons. This critique reflects the challenges raised by women-centred feminist perspectives in Evans' schema.

Harding also questions the use of what she terms 'victimology' where research focuses on areas where women are seen only in the role of a victim, as this can be seen to give a false and generalised portrayal of women and their experiences. In application to the research project, to presume the women interviewed were oppressed and required emancipation could be interpreted as a victimological assumption. Here clarity is required between positioning women as 'victims' and acknowledging their oppression and disadvantage in a society premised on patriarchal values and institutions. I perceive that Crenshaw, in positioning Black women as having different experiences of discrimination based on both their gender and ethnicity does not present them as victims, rather, as a group within society who are disempowered as a result of unequal distributions of power.

Harding does advocate research that is inclusive of women from the development stages and recognises that this research should be 'for women' in its aims. This directly corresponds with a critical theorist perspective in the use of research for enlightenment and emancipatory aims. As stated previously, this thesis did not begin as feminist research, which means to suggest that the aims were focussed on female empowerment, or that women were involved with the design would be incorrect and unethical. However, as the process of identifying participants evolved, so did my understanding, leading to a much

closer connection to the feminist perspectives described above and in chapter 4. The challenges of managing this process were both practical and personal and are described later in this chapter.

Harding's final criteria for useful feminist research urges researchers to view the 'objective as subjective'. Harding is referring to the inherent bias in what are seen as objective research outcomes, this applies to the type of data collected and the methods used in analysis. This approach would argue that as men have been the decision makers in what data is collected, this gender bias will continue throughout the research process and influence results. The author does not dismiss the results of research that falls into this category, rather expects that the researchers acknowledge and explore the influence as part of their analysis. The methodological decisions in this thesis have been made with the explicit desire to ensure that the women's narratives are retained as a whole. This is reflected in the reporting of results as case studies, and in the understanding of the analysis process as subjective and grounded in the co-constructed nature of meanings generated. The importance of representation is explored later in this chapter.

5.3 The Research Project

The aims of this research have evolved as my knowledge has developed, with some initial objectives now recognised as inconsistent with the values, ethics and underpinning philosophies of social work research, where this study is located. Reconciling the discomfort of being situated in an organisational context, whilst wanting to conduct research that upholds the values that the social work profession is based on (discussed later in this chapter) meant that new objectives, more fitting with my personal beliefs have been developed;

1. Explore Pakistani older women's experiences of health and social care in the UK
2. Explore the relationship between Pakistani older women's experiences and their under-representation in health and social care services
3. Explore the impact that these experiences have on Pakistani older women's identities

4. Contribute to improving support in a meaningful way by providing a platform for Pakistani older women's narratives to be heard

The terms 'explore' and 'experiences' within the first three aims are consistent with interpretivist perspectives. Recognising that understanding people's experiences is privileged over attempting to extract facts also fits with an idealist-interpretivist tradition. The acknowledgment that there is an under-representation of some populations using services resonates with a critical theorist paradigm, where disadvantage is identified. The final two aims specifically address the impact that under-representation may have, and acknowledges that older Pakistani women, particularly those that don't have English language skills, lack a platform from which to share their experiences. It is important, from an interpretivist position, not to make deterministic assumptions about why there is under-representation of some groups within some services.

Having social work practice experience in the geographical area, and in the services where under-representation is observed does mean that my subjective understanding of the issues needs to be addressed when analysing the data. The methods described later in this chapter enable this knowledge to be considered and utilised within the analysis.

This thesis therefore, takes a flexible social constructionist position, understanding that although a fixed reality may not exist, socially constructed realities are developed based on interaction with each other and our environment. Lending from both interpretivism and critical theory, these socially constructed realities can only be known through exploring experiences, and these experiences are shaped by constructed hierarchies of power. Intersectional feminism then contributes an emphasis on the constructed hierarchies of power that oppress and disadvantage women differently, in conjunction with other power hierarchies.

5.4 Social Work Methods

When considering which approach to utilise for this thesis it was important to me as the researcher to use methods that corresponded with my social work profession, values and ethics. McLaughlin (2012:9) asserts that 'research, like social work, is value driven', this

resonates with the idea that the researcher plays an important role in their choice of research, analysis methods and outcomes. They are inextricably linked to their values in choosing a subject matter, method and relationships with participants, although McLaughlin (2012) and Riessman (2008) see these as complicated by external drivers such as funding, policy decisions and budgets.

McLaughlin (2012:9) identifies something unique about research from a social work perspective compared to that undertaken by other 'disciplines', commenting that 'social work research thus aims not only to support practice but also to transform it'. There is a parity here with both interpretivist and critical theory paradigms. Willis proposes that interpretivist researchers see a reciprocal relationship between practice and research compared to the enlightening and emancipatory qualities critical theorists believe research to have - indicating a lack of reciprocity with research guiding practice not vice versa.

Social work is concerned with empowerment, advocacy and emancipatory work. Since the 1980s and 90s in England, the profession has also been focused on anti-oppressive practice, as a result of ethnic and racial tensions (McLaughlin 2012), which coincides with the emergence of multicultural policies (described in chapter 2). Dominelli (2002:26) identifies anti-oppressive practice as that which;

addresses social divisions and structural inequalities in the work that is done with 'clients' or workers. Anti-oppressive practice aims to provide more appropriate and sensitive services by responding to people's needs regardless of their social status

She continues to describe the approach as;

a way of structuring relationships between individuals that aims to empower users by reducing the negative effects of hierarchy in their immediate interaction and the work they do together

These objectives can be applied to both social work practice and research. The author draws attention to the structural aspects of oppression and disadvantage, acknowledging that discrimination can affect the life chances and opportunities available to individuals and that part of the social work role is to challenge this social injustice. This reflects the critical theorist position, however the extent to which social workers can have an impact is challenged by some.

5.4.1 Critical Social Work

The social work profession, like research, has many different philosophies and approaches that develop and adapt in relation to the requirements of its consumers. Adopting a critical theorist perspective enables us to understand these requirements to be developed as a result of power hierarchies. In social work the source of this power is located in political decision making and enacted by institutions such as local authorities and the NHS. As a result of this understanding, a collection of social work perspectives have emerged, identified as critical social work (Fook 2012, Ferguson 2008).

The majority of critical social work perspectives accept a structuralist philosophy to some degree, whereby the powerful, located in structures and institutions, maintain and facilitate the oppression and disadvantage experienced by those using services. As Healy describes; 'critical social workers claim to direct practice towards the eliminating of the original structural causes of problems faced by social workers' (Healy 2000:5). The acknowledgment of power structures as external to our experience of them is problematic from a social constructionist perspective, however, with the understanding that these structures have developed as a result of shared understanding, rather than because of an external reality, the two positions can sit alongside each other.

Bourdieu's (1989) work on capital can explain critical social work by proposing that in the field of social work, or service use, capital is unevenly distributed between both professionals and service users and different professions themselves. Social construction can help us to understand the changing nature of practice (or the field), and the fluidity with which different service user groups are prioritised. Historically social work is connected to the concept of 'deserving and undeserving', with the title of undeserving being passed from one group to another.

According to Healy (2000:3), critical social work perspectives are united in 'an orientation towards radical social transformation', whether this be by dismantling power structures or challenging the construction of certain groups as undeserving. Four shared emphases define this approach;

1. Standing alongside oppressed populations

2. Importance of dialogic relations between workers and service users
3. Role of social, economic and political systems in shaping individual experiences and social relationships, including interactions within practice context
4. Commitment towards researching and moving towards change, actively provoking change by transforming processes and structures that oppress and exploit (Healy 2002:3)

It is with these four principles in mind that the revised aims of this thesis were developed.

5.4.2 Narratives and Social Work

Riessman and Quinney (2005) conducted a literature review of the use of narrative in social work research, stating that 'narrative frameworks can honour social work values and ethics, by valuing time with and diversity among people' (2005:395). The authors concluded that disappointingly 'social work has embraced narrative concepts for reflective practice and teaching, but only to a very limited degree in research'.

Since the completion of this review, Hafford-Letchfield (2015) compiled the publication: *Guide to Using Narratives in Assessments with Older People* for Community Care Inform. In this guide the author explores the contribution narrative methods can make to social work with older adults, in relation to both direct practice and the broader social justice agenda. Reference is made to the usefulness of narrative in a variety of settings, including transitioning to older age, bereavement, dementia and assessment processes, facilitated through several different methods, for example through life-stories, biographical work and the adoption of first-person assessment frameworks.

Hafford-Letchfield understands that, similar to narrative researchers 'the social worker has to enter the older person's world and positively contribute' (2015:7), she encourages the practitioner to be 'aware of [their] own role in the construction of biography'. Here the author recognises the co-constructed nature of narratives, and the importance of understanding the social worker role in developing and shaping a positive sense of self.

Challenges to the use of narrative are presented, although these relate specifically to the practical application of the method in the practice arena. The author identifies three key

issues; lack of time, insufficient or inappropriate assessment tools and lack of resources to provide suitable interventions. The guide concludes that that 'narrative can provide a vehicle for social change, given that individual and collective narratives are closely intertwined and situated in a social-cultural context' (2015:14). This is important for the present study, which has an emphasis on informing and developing services. The suggestion that narratives can facilitate change is particularly important given Butt and O'Neill's (2004) finding that the South Asian population are over-researched in the health and social care field but with no focus on change.

5.5 Use of Narratives

5.5.1 Defining Narrative

Narrative approaches are clearly linked with an interpretivist paradigm and the branches of analysis recognised under its umbrella. Riessman (2005, 2008) is clear in her assertion that there is no one definition to encompass what narrative research 'is', instead she proposes that the definition is fluid on a spectrum dependent on discipline and context, with some researchers preferring a loose definition and others adhering to a rigid inclusion criteria.

Although a key proponent of narrative research, Riessman consistently guards against 'the tyranny of narrative' (2008:4) in her writing. By this she is warning against the overuse of the phrase to define all or any spontaneous speech or writing as this will dilute the usefulness of the method and its research outcomes. Rather Riessman and Quinney (2005:394) identify that in psychology and sociology 'personal narrative encompasses long sections of talk - extended accounts of lives in context that develop over the course of single or multiple interviews'. An alternative, and more formal inclusion criteria to define a narrative is Labov's (1972 cited in Riessman 2008) definition of a 'full narrative' which has six elements;

1. Abstract
2. Orientation
3. Complicating action
4. Evaluation

5. Resolution

6. Coda

Although Riessman acknowledges that not all six aspects of a narrative are required to be classified as a full narrative, this criteria is still frequently utilised in structural analysis methods. The present research project includes participants who share their stories through an interpreter, therefore, setting a fixed and comprehensive expectation of narratives is not realistic.

5.5.2 The Narrative Turn

Riessman is not the only researcher who advocates narrative approaches, however she combines this method of data collection with the importance of performance in her use of dialogic performance analysis of her interviews. As this is a combination I have also chosen to use for this thesis, it is helpful to use her work as a guide.

The 'Narrative Turn' refers to the emergence and increased use of narrative as a recognised research method. For Riessman this was shaped by four converging movements; initially the growth in critique of positivist inquiry based on realist epistemology sparked interest in methods that focussed on relativist epistemological positions. Also contributing was the 'memoir boom' in literature, which relied heavily on biographical and autobiographical narrative to tell emotive stories. The influence of this movement in raising the profile of narrative can be directly linked with social work. Many of the texts categorised as memoirs also include a social work aspect. Recent examples of this include the award winning '*A Child Called 'It''*' (Peltzer 1995), '*A Piece of Cake*' (Brown 2006) and most relevant, the '*Hackney Child*' (Hope and Livingstone 2012) all of which involved the authors retelling their childhoods through use of narrative, and all of which included their involvement, or lack of involvement with the statutory social work system. Added to these factors was the growth in identity and rights movements of the 1960s and 70s which raised awareness of the diversity within humanity. This can be seen in alignment with the interpretivist tradition of exploring individual experiences rather than seeking to establish similarities and patterns as a positivist position would advocate. Finally, the growth of a therapeutic culture (Explored by Furedi 2003) where talking therapies are frequently prescribed as treatment

for a variety of 'low level' mental health issues has contributed to the increased familiarity with the idea of using narratives in everyday life.

Narrative methods can be seen as culture specific and the increase of 'therapy culture' in western countries is one aspect of this. Riessman identifies that throughout the life course, western individuals are asked to 'self-narrate' on various occasions, leading to a familiarity with the expectations and format. This idea of cultural specificity presents a concern about the usefulness of narrative as a method for use with the participants in this thesis, who are all of Pakistani origin. I decided not to seek out an alternative method, as I believe that using an unfamiliar method adds to the richness of the data provided. The use of narrative interviews as a specific method of data collection in this context will be analysed and will contribute to the final outcomes. In addition to this justification, Riessman herself utilises this method to research women from the South Asian subcontinent in her research into infertility in India (Riessman 2002 in Inhorn and Van Balen).

5.5.3 Narrative Interviews

Narrative interviews must recognise the importance of the interviewer; 'the researcher does not find narratives but participates in their creation' (Riessman 2005:21). Here Riessman is alluding the position that meaning is co-constructed by the participant and interviewer together during an interview. They influence each other and build a shared understanding of the subject. It is because of this requirement of shared understanding, that it is important for the interviewer to also be the investigator. Interpretivist perspectives bestow great importance on individual experiences. Where a positivist approach may see the shared role of interviewer/researcher as reducing the validity of the outcomes due to lack of objectivity, this is in direct opposition to interpretivist research. It is acknowledged that objectivity is not only impossible, but also not desired, as the relationship between participant and interviewer can and should influence the interpretation. As the investigator, I will be conducting all interviews for this thesis.

Interviews conducted using this method 'necessitates following participants down their paths' (Riessman 2008:24). Interviewers follow the lead of the participant in guiding the conversation and keep their prompts non-directive and minimal in order to allow the

participant as much freedom as possible. There can be a sense of loss of control experienced by the interviewer as they must not steer the conversation.

In order to conduct interviews in this way, an open-ended question is required, however the question must also direct the participant to recall a specific time or event, in order to enable them to present a 'story' rather than a more generalised response. For this research project the question is;

'please tell me about an encounter you have had with health or social care in this country'

This was decided upon as it indicates the requirement of one specific example, without closing this down to a short response. Riessman describes that 'the specific wording of a question is less important than the interviewer's emotional assertiveness and engagement and the degree of reciprocity in the conversation'. This is not a position of consensus however, as Bakhtin asserts that 'words carry history on their backs' (1981 in Riessman 2008:107). Here he is referring to the increased relevance of specific word use and reads much more importance into word choice. This is an important factor in this research project as the interviews were conducted via an interpreter. Use of exact translation is not always possible or suitable in this situation and therefore there is a reliance on engagement and reciprocity to compensate for the lack of direct communication. Bakhtin's position is credible and word choice is important, particularly when noting patterns or repetition of words or phrases, however due to the use of interpreters this is a level of analysis that is challenging. Because of this challenge, word choice and repetition is considered within the analysis, however expressive sounds are given less attention, as these were often used when interpreters were thinking of an appropriate word as well as to emphasise a point.

I considered utilising independent transcribers to transcribe the Urdu and Punjabi exchanges in the recordings, to compare with my transcriptions of the English exchanges, however I felt that this conflicted with both my value base and epistemological position, described below.

1. Trust is incredibly important in social work, and hence in social work research. I believe that to have the recordings transcribed so that I could analyse the Urdu and Punjabi sections could be understood as 'checking' that what had been relayed via the interpreter was accurate. As the interpreters on most occasions were family members, I felt strongly that this would ruin the relationship between us. I come from a position that the co-constructed narrative is created by us all and therefore there is no need to externally validate the results.
2. From an interpretivist perspective the role of the researcher in interpreting the data is fundamental to the outcomes because of the relationship between the two. To use externally transcribed data would disturb this relationship, my ability to immerse myself in the data would be lost, as I would never have heard the words spoken. In my opinion this type of data would require a different form of analysis, premised on a different epistemological position.

Proponents of narrative interviews suggest that multiple visits to participants can gather richer information than one off interviews (Hollway and Jefferson 2007, Riessman 1993, 2005, 2008). For this thesis only one-off interviews were practical for a number of reasons; primarily because the women were not offered anything in compensation for their time. It felt intrusive and an abuse of power as a researcher to expect participants to accommodate me in their homes on more than one occasion without something in exchange. It could be argued that the outcomes of the research would eventually benefit these women, or that altruistic reasons would compel them to agree to further interviews, but my personal opinion, based on the social work value of respect was that one visit would enable me to gain sufficient information and reduce my intrusion on their private lives. This was compounded by the fact that all the participants chose a relative to interpret for them, meaning that two members of the family were inconvenienced by their participation.

To address the single interview status of this thesis it was even more important to ensure a relationship was forged with participants prior to the interviews so I arranged to attend the luncheon club once a week for several months prior to the interview stage. The women met at the community centre about an hour before lunch was served and chatted about their lives - in their first language which was, in most cases Urdu or Punjabi although some

women also spoke Gujarati. This posed challenges for me as an 'outsider' as I could not communicate with the women in their language, nor they in mine but I still needed to try and establish a relationship where they would be willing to participate in the project. Although best practice in terms of narrative interviews was not followed here, and only one interview was conducted per participant, the time spent with the women at the community centre was valuable in allowing me to begin forming relationships with them.

5.6 Dialogic Performance Analysis

Riessman sees narrative analysis as divided into four categories; thematic, structural, dialogic performance and visual. Dialogic performance analysis is seen as a hybrid approach, developed by combining elements of both thematic and structural analysis where the researcher/interviewer 'becomes an active and visible presence in data gathering, analysis and in the written report' (2005:42).

5.6.1 Transcribing

The above dictates that the method of narrative analysis chosen influences the method of transcription. Dialogic/performative analysis acknowledges the importance of co-construction; therefore, the interviewer's spoken words, pauses and non-verbal exchanges are equally as important as the participant's in the analysis and need to be present in the transcription. This approach can be compared to those based on the idea that the self is already constructed, here interviews would simply allow the participant the space to present this pre-existing self. From this position, the role of the interviewer/researcher is minimal, and therefore their presence in the transcript is not required. As I am taking the former position presented here, the communication (spoken language and sounds) of both the participant and interviewer will be transcribed.

The inclusion of the interviewer's interactions in the transcripts is in keeping with Jenkins' (2014) understanding of identity as social, developing in interaction with others, and the environment. This approach accepts that both the interviewer and the participant generate shared understandings, responding to each other's direction. In the current study the role of the interpreter also requires consideration; all interpreters are family members

or friends of the participant and are often the person who would attend health or social care appointments with them. This means that they also have a valuable account to contribute and become a hybrid interpreter/participant. Poindexter (2003a) refers to the transcription of interviews with three speaking roles as generating a 'trialogue', which is a fitting definition for this thesis.

5.6.2 Analysis

Dialogic/Performative analysis is characterised by understanding speech as a performance, a perspective taken from Goffman's work on performance. Transcriptions or recordings of these performances are analysed by applying a number of principles;

1. Subjectivity in interpretation - this principle recognises that the researcher's interpretation relates to their own interests and agenda. In application to this research project it needs to be recognised that I am researching a specific topic, the choice of which is a result of my own subjective experiences as a social worker in the geographical area being researched. Therefore, the question I pose to participants is designed to illicit a response about a very narrow aspect of their lives. This response is then the focus of much deeper analysis. Riessman's point here is that by gathering information in such a way, the importance of the narrative given to the participant can be conflated by the researcher. The author refers to incidents in her own research where participants have read her interpretations and reported such issues to her, explaining that they hadn't seen the issue researched as having the prominence in their lives that it was given in the interpretation.

2. Interpretation must be linked to features in the text - interpretivist research by definition requires the interpretation of the researcher to illicit meaning from narratives. As the approach acknowledges the importance of the researcher in constructing this interpretation, one can deduce that a different reader may attach different meanings to/identify different aspects of the narrative as important. For Riessman it is this variety that necessitates the connection between interpretation and features of the text, put simply the interpretation must be traceable in the transcripts. It is from this principle that we can justify the decision for the researcher who conducted the interviews, to both

transcribe and analyse their own research, as their connection to the data is much stronger than just the words on a page.

3. In combination with the importance of text, an understanding of context is required. Where interpretation appears to divert from the transcribed narrative this must be explained by features in the contextual lives of the participants. This is where the researcher possesses knowledge that readers may not have available to them. Contextual factors may include political climate - in reference to the research project the financial insecurity of the community centre may have affected the women's likelihood of participating. Political climate and international issues such as a recent natural disaster in Pakistan may also have affected the responses of the women. This additional information affords the interpreter a more holistic understanding of the participant's responses.

4. In relation to the 'performative' aspect of dialogic/performance analysis Riessman (2008) recognises the way the way the participant chooses to present their narrative as fundamental to the interpretation, alongside what they choose to present. Here she identifies features of the participant's spoken language within the narrative that require further analysis and exploration;

- primarily the use of direct speech to report or reconstruct a conversation that occurred between 'actors' in the narrative. This can be seen as building credibility and can also enable the participant to convey a message that they may be uncomfortable stating as their current selves.
- The use of 'asides' interchanged with the use of direct speech can be used as a strategy to engage with the audience (researcher in this case) and build on the relationship.
- Riessman sees the repetition of words or phrases as indicating importance or relevance of a particular aspect of the narrative, she recognises that individuals will revisit aspects of their stories that they want to convey as important.
- Use of expressive sounds is seen as a feature worthy of exploration as the attempt of the participant to add 'drama' to their narrative. This aspect influenced to the decision I made to transcribe the sounds of the participant and the researcher, along with the language spoken. Linked to the recognition of sounds is the

importance of pauses and breaks in language, which may indicate emotion or discomfort for example. The difficulties with interpreting expressive sounds in this way with translated content are discussed earlier in the chapter.

- Use of alternating 'historical present' and past tenses in language can indicate a deeper involvement with the subject being conveyed. This may be in subconscious attempt to engage the audience with this aspect of the narrative or because this aspect is more emotive or important to the participant.

As discussed in the last chapter, Goffman applies a spectrum to the presentation of self, from sincere to cynical, dependent on the level of insight the individual has into their performance. This is equally relevant to the use of the linguistic features above; in some instances, participants and their interpreters chose certain words or discussion points to emphasise because they were aware of my research aims but at other points this was not the case. This is explored in relation to the transcripts throughout the next two chapters however here it is important to discuss the researcher's 'self'.

5.6.3 Audience

Riessman and Goffman suggest that in all human interaction, people adapt their performance to the audience, and that an 'audience' can be a physical or implied presence; for example; as the interviewer, I am a physical audience, but cultural expectations can also influence performance. Mischler (1986 cited in Riessman 2008) suggests that the interviewer can represent three audiences;

1. The interviewer as an individual; seen when participants talk to me about my family, for example one woman asked me who was watching my son while I interviewed her in the evening.
2. The interviewer as a representative of their profession; often once interviews had ended, and occasionally within them, participants and their families would ask me how to access social care services or apply for benefits.
3. The social and cultural context; All interactions are influenced by events and expectations; local, national and international, for example participants were

occasionally reluctant to be audio-recorded because of a recent incident where women had been photographed at a group without headscarves on. These photographs had then been posted on social media without their full consent. This altered the dynamics of trust when forming relationships and conducting interviews.

My individual relationship with the women, developed over several months attending a weekly luncheon club provides the participants with expectations of my 'individual self'. This is combined with the awareness of my previous employment as a social worker and my present position as an academic, which contribute to the 'professional self'. The interviews are conducted in the women's homes, situated in an area that has a high Pakistani population compared to national averages, has experienced significant unrest and is described as the most deprived in England in 2016. The unique 'audience' is formed where the three different aspects combine.

This level of subjectivity and uniqueness could be perceived as affecting the validity of the project, however following the points developed by Riessman (2008) ensures that the analysis is tied to the transcripts and justified by reference to the text, performance and knowledge of the social context.

5.7 Thematic Analysis

Once the individual participant transcripts were analysed using dialogic performance analysis, it was important to identify whether common themes could be interpreted from the data. The development of common themes would mean that despite the differential distribution of privilege and capital between the participants, based on intersectional disadvantage, there are commonalities in their experiences. These commonalities can then be used to generate recommendations for change. For this process, thematic analysis was utilised. Braun and Clarke (2006) define thematic analysis as 'a method for identifying, analysing and reporting patterns (themes) within data' (2006:7). The authors encourage researchers to recognise their influence on the process of thematic analysis, asserting that themes neither 'emerge' or are 'discovered' from the data, rather, the investigator analyses and develops themes. This process of analysis and development cannot occur external to

the researchers own influence, knowledge or interests, a premise in keeping with dialogic performance analysis, which also accounts for the co-constructed nature of narrative research.

According to Braun and Clarke, thematic analysis involves utilising specific terms, described below in relation to this thesis:

- Data corpus – all transcripts
- Data set – all narratives (identified through the flexible application of the definition of a narrative, and relationship to the research question)
- Data item – individual participant transcript
- Data extract – individual narrative

In keeping with the philosophical underpinning of this thesis, theoretical thematic analysis was utilised. This form of analysis is based on researcher interest, and coding of the data extracts is influenced accordingly, although in line with dialogic performance analysis, interpretation of meaning must also be observable in the transcripts when considered across a single data item. In addition, the analysis was conducted at interpretative or latent level. This means that analysis focussed on thematising meaning rather than the words of the data extracts alone, this is important as dialogic performance analysis had been completed and meaning already interpreted from features of both the language and performance of the participants.

Once theoretical decisions about the analysis had been considered and finalised, thematic analysis was conducted utilising Braun and Clarke's six phase process, listed below (2006: 35);

1. Familiarising yourself with your data
2. Generating initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the report

Appendix four provides a diagram of the thematic maps generated at phase four, and appendix five shows the refined subthemes completed at stage five.

5.8 Using Interpreters

Many of the participants in this study were unable to speak English, with some describing their language skills as 'bad' or 'limited'. In addition, I am unable to speak in the first language of the participants (Urdu, Punjabi or Gujarati). Because of this language barrier, an interpreter was required for five of the interviews. All participants were offered a choice of interpreter; I could organise a formal interpreter via an agency or they could arrange someone they felt comfortable with to support them, everyone chose the latter.

Interpreters are frequently utilised within health and social welfare provisions in England in order to support the exchange of information between professional and patient/service user. This process is not unproblematic and requires exploration here.

5.8.1 Interpreting as a discipline

Although informal interpreting practice is presumed to date back as far as immigration itself (Mikkelsen 2012), researching formal interpreting as a discipline is a progression of the field of translation studies and can be traced back to work in psychology. Pochhacker (2012) describes the emergence of two schools of thought in the 1960s; one associated with cognitive processing (CP), referred to as the Paris School and pioneered by the French academic Seleskovitch and another exploring dialogic, interaction orientated (IO) work, influenced by dialogism and sociology.

These two distinct fields developed by studying interpreting in conference settings, with community interpreting only becoming recognised as a profession in 1995 (Mikkelsen 2012). Community interpreting is a contested term but usually refers to interpreting outside of largescale conference style settings, for example in health care or legal forums. This move to the community paved the way for interpreting to be seen as more of an interactive and dynamic process of mediating, rather than a static entity (Pochhacker 2012). Despite the developments described here, there is still very limited research exploring the nature of interpreting in health and social care, what is published focusses

mostly on provider perspectives rather than that of the interpreter or interpretee (Green et al. 2005).

Seleskovitch (1978 cited in Pochhacker 2012) proposed the 'theorie du sens' as a development of the cognitive processing discourse, stating that 'interpreting does not consist in transferring words but in grasping and re-grasping non-linguistic sense' (2012: 61). There are parallels here with Riessman's perspective, whereby meaning is ascribed to transcribed words in conjunction with analysis of the performative and contextual aspects of interaction. Using Riessman's method of dialogic performance analysis with foreign language interpreters can therefore be seen as a hybrid, reflecting aspects of both interaction-orientated and cognitive processing perspectives.

5.8.2 Theoretical problems with formal interpreting

The literature review in chapter 3 describes the practical problems that service users experience when using interpreters to enable their access to health and social care services, however the use of formal interpreters can be challenged at a theoretical level. The idea that interpreters must 'make sense' of information before recreating it in the language of the participant reflects the understanding that this process is subjective. Lending from Jenkins' theory of social identity, we understand the interpreters' perspectives and beliefs shape the way they 'make sense' of the world and vice versa in a dialectic process. Mikkelsen (2012:392) contributes to this discussion, indicating that professional interpreters often worry about the consequences of their role. Describing that they express concern when 'deciding whether to render what the interpretee *says, means* or *should say*'. This suggests that the values and ethics of the individual interpreter also play a role in how information is presented. Considering Seleskovitch and Mikkelsen's understanding, the way formal interpreters are deployed by professionals instead of family members to relay information objectively can be seen as flawed.

In addition, Tipton (2010) raises the importance of trust in professional interpreter mediated social work encounters, describing that although there may be a lack of trust between practitioner and interpreter, both parties are privileged with more power than the service user. The dependence of the service user on both the social worker and

interpreter to meet their needs, means that they are in a difficult and disadvantaged position, described by Tipton as requiring a 'leap of faith' in order to place trust in the professionals. The option for participants to choose their own interpreter in the present study is an attempt to redress this power imbalance.

5.8.3 Informal Interpreters

As described above, this thesis offers participants the opportunity to choose a family member or friend to interpret for them. Despite the evidence to the contrary, using formal interpreters is routinely thought to reduce subjectivity, with the practice of using friends and family to interpret formal interactions seen as unacceptable. Mikkelsen (2012) asserts that 'the use of ad-hoc non-professional 'interpreters' [...] is still distressingly widespread' (2012:391). The term distressing and use of quotation marks indicate the author's alarm at this practice. The NHS (2015:2) warn that the use of inappropriate interpreters, including family and friends 'may make their use more high-risk, than having no interpreter at all'.

Green et al. (2005) explore the role of bilingual young people in interpreting for their family members, describing this practice as perceived as problematic and as a result of 'deficiencies either in parent's language skills or in the provision of professional interpreting services' (2005:2098). They outline the deficit of research that considers bilingual young people's perspectives on their interpreting role and suggest that providers perceive the practice to place a burden on such children.

In opposition to these common assumptions, the authors indicate that the young participants valued their role as interpreter, perceiving their bilingual status to be an important aspect of their self-identity and their use of this skill as a social responsibility. Young people described two categories of problem with conducting their role, summarised below;

1. Technical challenges;

- Vocabulary limitations – comparable words didn't exist in both languages
- Professional frustration - when the professional is unable to directly communicate with the patient
- Interruption – by the family member for whom they were interpreting

2. Mediating, advocacy and role conflict;

- Tensions in expectations – either party expecting them to choose a ‘side’
- Embarrassment – interpreting sensitive information
- Gender conflict – when the interpreting role required gender specific information to be shared, incongruent with usual cultural practices.

The challenges described by young people here are not unique and could also be encountered when using professional interpreters. Despite the problems, Green et al. (2005) found that the young people were positive about their experiences, feeling that they were valuable in contributing to supporting their family. Although the interpreters in the present research are all adults, the results of this study are relevant, with the exception of vocabulary limitations, where a child’s knowledge may limit their ability to access comparable terminology.

5.8.4 Co-Construction

Research indicates that despite the presumption of formal interpreter’s ability to ensure an accurate and unproblematic mediation between researcher and participant, the problems presented as existing for informal interpreters are actually also present during formal interpreter interactions. The difference between the two, according to Tipton (2010) relates to the location of power and control; when professional interpreters are involved, the practitioner has more control, whereas when the participant or service user provides the interpreter, this counters the power imbalance to a degree. It is with this knowledge, and the desire to address this imbalance in order to create a supportive atmosphere, that participants in the present study are offered the choice of interpreter.

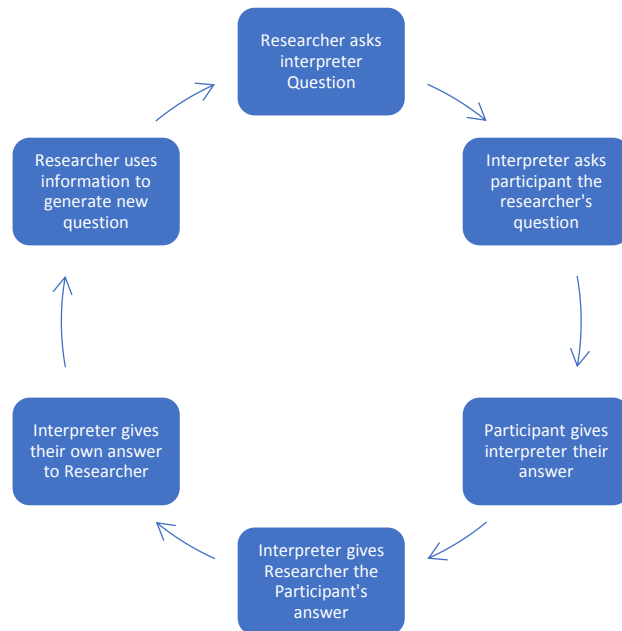
Riessman (2008) describes the use of dialogic performance analysis to analyse interviews conducted via an interpreter, however in her research the interpreter is her professional associate, not previously known to the participants. The author describes that ‘investigators can include themselves and translators as active participants in knowledge production’ (2008:49), indicating that the development of understanding within the trialogue is dependent on all three parties. This trialogue becomes more complex when the interpreter is the person who accompanies the participant to the appointments to be

discussed in the interviews, as this level of knowledge may interfere with the presentation of the participant's perspective. Conversely, this addition to the co-construction can also be perceived as beneficial, as the interpreter-participant relationship and process mirrors that which already occurs within the context of appointments, enabling the researcher to experience a similar encounter. Any problems identified by the researcher in the interpreting process would also be experienced by professionals.

Riessman suggests that when analysing interpreter-mediated interviews, 'particular words and lexical choices' (2008:42) cannot be interrogated, based on her work with a colleague as the interpreter. Instead the author recommends utilising interpretation of other linguistic features such as volume, pitch and expressive sounds. I believe that as this thesis involves family interpreters, who have experience or understanding of the encounters being described, there is usefulness in analysing the words and phrases of the interpreted narrative alongside the additional features Riessman proposes.

The narrative presented to the researcher by the interpreter has already undergone co-construction at several levels. The diagram below shows the cyclic nature involved in producing the unit of analysis, with co-constructed meaning developing at each stage;

5.8.5. Diagram 1: Process of co-construction in interviews



5.9 Legal Frameworks

Health and social care in England is governed by a mass of legislation and policy, much of which will have guided the actions of professionals in the interactions shared by participants. Included in these documents is reference to the use of interpreters. As discussed above, peer reviewed evidence considers use of family and friends as inappropriate due to presumptions of subjectivity, but similarly there is evidence to indicate that professionals also interpret subjectively. From a social constructionist position, subjective experience is the only way that people can understand their interactions and environment as one external objective world does not exist. Recognising this, from both a theoretical and research position, the assumption that objective interpreting can occur is refuted. Despite this, much of the legislation recommends the use of professional interpreters;

5.9.1 Equality Act 2010

The Equality Act (2010) offers legal protection from discrimination for individuals or groups in possession of one or more of nine protected characteristics, one of which is 'race'. Section 149 of the Act describes the duty for public authorities to 'eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act' including the need to 'remove or minimise disadvantages suffered by persons who share a relevant protected characteristic'. It is this duty that ensures the provision of an interpreter for individuals whose first language is not English.

5.9.2 Mental Capacity Act 2005

The Mental Capacity Act (2005) is used to promote the rights of individuals whose decision-making ability is questioned. It includes five statutory principles to ensure that rights are upheld. Principle two involves ensuring that individuals are supported to make their own decisions and are given 'all practicable help' to do so. The Code of Practice asks practitioners to question 'could anyone else help with communication?' (2016:52) including the use of interpreters. Principle ten of the guidance expands to include the following advice;

if necessary consider using a professional language interpreter [...] it is often more appropriate to use a professional interpreter rather than to use family members (2016:53).

5.9.3 The Care Act 2014

The Care Act (2014) outlines the overarching duties for social care professionals working with adults, including provision of information, assessment, intervention and care planning. The Act is underpinned by the 'well-being' principle, which ensures that individuals are fully involved in all decisions about their care. The corresponding guidance acknowledges the requirement to use interpreters to ensure that the assessment process is Equality Act (2010) compliant, describing; 'it is not normally appropriate to use a family member or carer as an interpreter, though sometimes this is appropriate'. The guidance continues to offer the example of an individual with a unique method of communication as a situation where a family member may be more suited to interpreting.

5.9.4 NHS England

In 2015 an NHS England policy statement was issued, presenting principles for high quality interpreting and translation services, including the expectation that interpreting services should be free, pre-bookable by patients and offer timely support whilst ensuring that additional consultation time is allowed. Principle four of this document describes the 'personalised approach' and advises professionals against the use of family or friends as interpreters when interacting with patients;

the use of family, friends or unqualified interpreters is strongly discouraged in national and international guidance and would not be considered good practice (2015:5).

The principle outlines that family and friends should only be utilised in emergency cases, and even then, only once safeguarding and competency issues have been considered. The guidance advises that if patients insist on family members providing language brokering, then informed consent must be established in the patients first language.

It is evident that although there are no legal grounds to forbid the use of family as interpreters, it is discouraged within both health and social care practice. This means that the power and control in the relationship with patients is often weighed against them, which can be particularly uncomfortable for patients and service users when discussing intimate or personal details. Sexton (2012) discusses this disconnect in relation to the Mental Capacity Act (2005), identifying a contradiction between the emphasis on relationship-based practice in social work and the expectation of service users to be able to make individually accountable decisions. The author understands the self as developed in interaction with others, and therefore challenges the notion that individuals routinely make decisions without consulting their 'decision community'. Sexton therefore questions the ethical basis for expecting individuals to make difficult decisions about their lives, often in circumstances of crisis, without the support of their family and friends.

Although the legislation listed above does not specifically exclude family and friends, it does suggest that this involvement be restricted, particularly when the professional involvement relates to individuals who may be at risk due to cognitive impairment or safeguarding concerns. The underlying suggestion in restricting involvement here is that family and friends are implicated in wrongdoing, which then has the potential to inhibit the development of good relationships with professionals.

5.10 Research Ethics

5.10.1 Social work values and ethics

This thesis is located in the social work discipline, which in England is a registered profession, meaning that practitioners must be appropriately qualified and registered with a regulatory body, currently the Health Care Professionals Council (HCPC), which is responsible for the regulation of sixteen professions. In order to remain registered, practitioners must ensure their knowledge remains current, by completing training and recording their learning in a continuing professional development portfolio. Registrants must also abide by the Standards of Conduct, Performance and Ethics (HCPC 2016), which establishes ten standards to adhere to. Failure to meet the standards enshrined in the code can result in fitness to practice procedures being initiated. Social work researchers who

remain registered as practitioners must continue to meet the standards within their research activity, although the extent to which a multi-professional code can reflect the distinct challenges of each area of practice has been contested (Butler 2002).

Prior to the HCPC assuming regulatory functions, the British Association of Social Work (BASW) developed a Code of Ethics specifically for the profession, recognising the unique focus on 'respect for human rights and a commitment to promoting social justice' (BASW 2014) as core to social work practice. This Code acknowledged the International Federation of Social Work's (IFSW) global definition of the profession, which includes the 'academic discipline' alongside the 'practice-based profession';

Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing. The above definition may be amplified at national and/or regional levels. (IFSW 2014 online)

The recognition of practice and academia working together to achieve shared goals reflects Butler's proposal that the two dimensions of social work require a compatible code of ethics;

the ethical foundation for a code of ethics for social work research is to be derived from the ethics of social work itself (Butler 2002:241)

The author identifies four core principles on which such a code should be constructed;

1. Respect for autonomy – including consent, confidentiality and no wilful deceit
2. Beneficence
3. Non-Maleficence
4. Justice

Butler indicates that combining these four principles can discern additional obligations, giving the example of bringing together respect for autonomy and beneficence to result in empowerment, another key principle for practice and research. It is with these four standards in mind that the current project has been designed.

5.10.2 PhD Research Ethics

As a PhD research project this study requires approval from the University Academic Ethics Committee at Manchester Metropolitan University, which is granted via submission of an Application for Ethical Approval form. Ethical approval was originally granted in 2013 but has been updated due to adaptations in the project, for example to the recruitment strategy.

Recruitment of participants was a slow process and other methods of contact were considered, including using posters to advertise the project. Approval was granted for this method however it was not attempted. Consideration of the literature relating to the stigmatising impact of racially divisive public health campaigns raised questions about the ethical nature of recruiting in this way. In reference to the four ethical principles discussed above, non-maleficence is the responsibility of doing no harm, therefore contributing to the discourse of singling out one ethnic group for research in such a public way without the ability to contextualise this via conversation could be perceived as breaching this principle, particularly when other recruitment strategies could be employed. In addition to this ethical challenge, members of the community centre suggested that written information would not help me to recruit participants, as different written and spoken languages were used locally, and many members of the community struggled with reading written information in their first language. I decided that given the difficulties, the recruitment strategy should remain as initially devised.

Because the luncheon club was run by volunteers who hired the space in a community centre, there was no formalised method of gaining consent as there would be for approaching patients or service users via NHS or local authority services. I discussed the aim of the project with both the volunteer organisers and the manager of the community

centre and provided them with a written summary of the study, this was agreed, and any amendments or updates were given verbally during my attendance at the centre.

5.11 Consent

Consent refers to acquiring a person's agreement or permission to be included, in this case as a participant in the current project, and is a fundamental part of research, with ethical approval panels expecting checklists and copies of a consent form to be submitted for approval. The consent form for this thesis can be found in Appendix 3.

The HCPC indicates the value it places on consent in practice by identifying it within the first standard of its code, this requires registrants to promote and protect the interests of individuals by ensuring 'that you have consent from service users or other appropriate authority before you provide care, treatment or other services' (HCPC 2016:5). The *BASW Code of Ethics* reflects this understanding of the importance of consent, suggesting that this must be 'informed consent' which must only be breached when 'required by law to protect that person or another from risk of serious harm.' (BASW 2014 online). The current project does not involve participants who lack capacity, nor do I expect to encounter persons at risk of harm, therefore consent must be ascertained from each participant.

Butler (2002) relates the requirement for consent to the social work research domain and includes the importance of appropriate language in ensuring consent is informed;

'consent must be secured through the use of language that is readily comprehensible to the research subject and which accurately and adequately explains the purpose of the research and the procedures to be followed' (2002:246)

This is directly relevant to the current study, particularly given the information outlined above in relation to the reading ability of participants. Consent was also a prominent concern as the members of the community centre had recently experienced a breach of their trust which resulted in photographs of the women without their headscarves being circulated via a social media page. This incident had made the members feel understandably wary about engaging with technology, particularly the audio-recorder.

5.11.1 Consent and the recruitment process

The project was explained to the whole group during the luncheon club meetings at the community centre via a member who also had experience of interpreting. Following this the women were asked if they would like to participate and to indicated this by raising their hands. It was also suggested that if the members did not feel confident raising their hand, or would prefer their involvement to be private, that they could approach me later in the session when I would sit outside the room.

As members raised their hands I took contact details for them and, if there were language difficulties, a suitable person to broker the meeting, some participants arranged their own interviews at this point, if they didn't require an interpreter. Consent was addressed for the first time here, as was the provision of an information sheet. Each potential participant was asked if they would like an information sheet and consent form in their own language sending to them prior to the interview, these were not pre-made due to the numerous different languages used at the centre. All participants declined this offer, preferring this information to be shared verbally. At this stage participants were also offered the choice between a formal interpreter and a family member or friend. All participants chose and nominated the latter.

Interview times were arranged via telephone, usually but not exclusively via the person acting as interpreter, occasionally one family member organised for another to attend with the participant, and two participants arranged their own appointment whilst at the club. Before beginning the recording, giving regard to the women's wishes to have information provided in English, the information sheet was read out by myself, and then offered to the interpreter who then read and interpreted this to the participant. I then asked if either party had any questions about the research. Some interpreters indicated that the request for information in English was due to both theirs and the participant's lack of reading skills in the participant's first language, therefore providing written information in this form would not have facilitated understanding for either the interpreter or the participant.

Following any questions resulting from the information sheet about the nature of the project, the same process was completed with the consent form. Once consent had been verbally ascertained, the interpreter had read the form and agreed that it reflected the verbal information, the form was signed by both interpreter and participant. Only once

consent was agreed was the audio-recording started, this was ensured again during the audio-recording at the end of the interview.

One participant declined to have her interview audio-recorded, she was very keen to contribute to the research, as were all participants, but the breach of confidentiality that resulted in the sharing of photographs had left her feeling uncomfortable being recorded.

Butler's reference to language in his proposed code does not necessarily relate only to non-English speaking participants, but also relates to the use of academic and discipline specific terminology. Standing (1998) addresses this in her work with women from low socio-economic positions, describing the use of academic language to present their views as exclusionary. This was considered both when devising the information sheet and consent form, and when describing the project verbally.

5.12 Confidentiality

Confidentiality is recognised in both the HCPC (2016) and BASW (2014) codes as fundamental to social work practice, and should only be breached in specific circumstances, for example when it is in the best interest of the person, or in the public interest. In practice maintaining confidentiality is a crucial part of building a relationship with service users, the establishment of strong relationships is promoted as essential for good social work practice.

Butler (2002) identifies confidentiality as one of the key aspects of practice that is also relevant to social work research, asserting that the identity of participants must only be made public when their consent has been sought prior to participation. This thesis did not seek such permission from participants and therefore their identity has been protected by use of appropriate pseudonyms. Pseudonyms are used instead of initials as it was felt that these enable the reader to achieve more of a connection with the participant's story. Substantial effort has been involved in choosing methods of data collection and analysis that enable each person's narrative to remain as a whole and pseudonyms are part of developing this connection. In addition, participant summaries are included in table four with the specific intention of generating a sense of who they are.

Confidentiality does not only relate to the use of pseudonyms in the writing up process, but also throughout the project. When interviews were recorded, codes were used to save the recording, these codes had no meaning to anyone apart from myself and hard copies of these were not stored, initials were not used. Participant information sheets and completed consent forms were kept in a sealed envelope in a locked drawer to ensure they were not shared, and participants were reassured that their identity would not be shared. As the women were approached in a group setting, they were aware of which of their peers had indicated an interest in participating, however this was not discussed during their interview. Occasionally someone would ask about a friend, who they were aware had also volunteered. Despite their knowledge of the other participants' involvement, I declined to confirm this – I was careful to ensure that this was done gently, and with a clear explanation of the reasons, explaining that although they may be aware of a friend's arrangement to be interviewed, I was not able to discuss this.

The geographic location of the project is also important, as dialogic performance analysis depends not only on analysis of the language and performance aspects of the participant's narrative, but on the researcher's ability to understand this in context (Riessman 2008). Events unique to the town play a role in this context, and therefore it is important to locate the project accordingly. Care has been taken however, to anonymise the location of the community centre, and the different areas of the town. In addition, direct references to the town itself have been removed from the transcripts, and discussions in other chapters of this thesis have been kept as generalised as possible.

5.13 Power

As discussed above, social work is rooted in the promotion of social justice and empowerment, which involves working alongside individuals in order to address and overcome the challenges they encounter. Part of this work requires social work practitioners to acknowledge their position as powerful, particularly when enacting their statutory duties, this issue is often presented as the dialectic; care versus control (Hardy 2015). Social workers must balance their ethical and value driven desire to support and empower those that they work alongside (care), whilst also performing controlling functions such as the removal of children or the detention of individuals for their own

safety (control). Critical social work theorists use this dialectic to refute that practitioners employed by the local authority, or performing statutory work (control), are able to simultaneously promote social justice or empower those that they work with (care), suggesting instead that social justice and empowerment can only come from working alongside the community to enact change (Healy 2000, Fook 2012).

Despite performing a research role, rather than a practice function, the participants in this study and the wider luncheon club group were aware of my previous employment as a social worker for the local authority in which they lived. This was recognised as a position that required specific knowledge, or cultural capital and despite several attempts to explain that I no longer had any association or up to date knowledge about the support offered by the authority, participants and their families still asked questions about this. Reissman (2002) describes a similar challenge in her research into infertility in India; despite her sociological background, the subject of infertility connected her to the medical profession, meaning that participants often hoped she could offer solutions to their fertility problems. Riessman does not describe how she countered these expectations; however, I developed a strategy in order to do so; during the time I spent attending the luncheon club, I learned about some of the common health and social care issues affecting the women and developed a list of contact details for relevant services. These included the initial contact team for the local authority social work department and the patient Advice and Liaison Service (PALs). If the members of the club asked me about specific services, I could direct them to this resource.

This method involved a level of discretion as lots of general conversation amongst the women related to health conditions or problems they were experiencing. To refuse to participate in these conversations would have been disrespectful and may have ruined my relationship with the club members, therefore, I engaged in these general discussions but made a concerted effort to separate my personal and professional selves. This meant consistently checking in with myself, to make sure I was aware of the power my advice may have, given the perception of my knowledge, and remembering HCPC standard three, which obligates professionals to 'work within the limits of your knowledge and skills' (2016:6). Recognising that I had not worked as a practitioner for some time and did not

have current knowledge of the available provisions, I would not be fully upholding this duty if I offered specific social work advice to the women.

5.13.1 Power and Representation

The interpersonal power relationship between myself and the participants can be described as part of a broader societal theory of power and representation, summarised here with reference to sociologist Stuart Hall.

Hall (2013) describes how humans have developed a system of understanding the world through grouping things into concepts and conceptual maps, to which corresponding symbols or language are attached. The author believes this shared understanding of reality enables us to relate to other people within our culture through representational systems. For example; there are many different types of chairs, but even a broken chair, or a chair with missing legs, or seat can still be identified as a chair, because we have developed a conceptual map which consolidates all attributes associated with chairs into one shared being; a chair. This explains why we understand a large armchair and a small wooden stool as falling under the same umbrella. This image is then transferred into symbolic form, by the use of a word, this word; 'chair', has shared meaning for all English speakers. According to Hall, it is these representational systems that construct meaning and, as with all constructs, this is 'produced within history and culture' possessing 'no single, unchanging, universal 'true meaning'' (2013:3).

Hall presents various theories to explain how the conceptual maps and corresponding representations are developed, however that of Bakhtin relates most directly to the method of analysis used in this thesis. Bakhtin describes meaning being developed through dialogue with the 'other', claiming that 'everything we say, and mean is modified by the interaction and interplay with another person' (cited in Hall 2013:224). This theory influenced Riessman's development of dialogic performance analysis and is evident in the recognition that narratives are co-constructed by participant and researcher. Additionally, Bakhtin's work is reflected in Jenkins' theory of social identity, whereby identity is developed in interaction with others.

Shared systems of representation are useful and enable us to communicate effectively with other people by grouping ideas together into 'types'. Dyer (1977:28) defines types as 'any simple, vivid, memorable, easily grasped and widely recognised categorisation in which a few traits are foregrounded and change, or development is kept to a minimum'. Comparably, the development of stereotypes has more serious implications. According to both Hall and Dyer, stereotyping involves reducing, essentialising, naturalising and fixing difference (2013:247), and enabling the exclusion of the 'stereotyped' other. Hall recognises that this process is most likely to occur where there are 'gross inequalities of power' (2013:247). These inequalities of power can be understood through reference to Bourdieu's work on distribution of capital, with possession of capital correlating with possession of power.

As a white, able bodied, educated professional, I possess power and capital that outweighs that of the participants in this study, who, despite their diversity are all from a minority ethnicity, are older and have some health conditions affecting their daily life. This difference in power distribution is described in relation to intersectionality in chapter four. Foucault suggests that, in relation to power 'no-one – neither it's apparent victims or its agents – can stand wholly outside its field of operation' (1980 cited in Hall 2013:34), meaning that both the participants and I understand the unequal distribution of power in our interaction. In relation to ethnicity, this power has been misused throughout history in many ways, to represent black and minority ethnic people as less human than white people in a racialised regime of representation (Hall 1981). There is, therefore, a responsibility, from an ethical position and from a social work position (recall Butler's third principle of non-maleficence) to ensure that this thesis does not contribute to this stereotypical misrepresentation of people.

5.13.2 Addressing Power and Representation

Saussure asserts that 'we can never cleanse language completely, screening out all other, hidden meanings which might modify or distort what we want to say' (1960 cited in Hall 2013:17). Here the author intimates that the negative associations of words and meanings will remain despite attempts to redeem them. This is an idea supported by Bakhtin, who suggests that 'words carry meaning on their backs' (cited in Riessman 2008:107), however,

given the constructed nature of meaning, there is always opportunity for development. Hall presents three possible processes for addressing stereotypes, he refers to this process as trans-coding, or re-appropriating meaning. The author outlines examples within recent history; primarily, reversing stereotypes, described as replacing the negative with positive but not disrupting the existence of stereotypes. A development of reversing stereotypes is the balancing of negative with positive associations, progressing the recognition of complexity, however without displacing the negative. Finally, Hall outlines the process of contesting representation from within. Here, rather than avoiding the focus of stereotypes, these should be channelled and used to dismantle pre-existing expectations, introducing new ideas and contesting binary notions of classifications such as race. Gunaratnam's (2003) concept of 'doubled research' can be seen as an interpretation of Hall's final process.

Gunaratnam suggests that this responsibility can be managed through the implementation of 'doubled research' practice. Doubled research refers to research that works with categorisations, acknowledging their problematic nature, in order to contest them and is described in more detail in chapter three. In relation to this research project, the shared Pakistani heritage of the participants was part of the criteria for recruitment to the study, however the analysis enables a spectrum of intersectional disadvantage to be exposed. Gunaratnam describes employing 'analytic hesitation' in order to prevent assuming that behaviour or experiences can be reduced, essentialised or naturalised to fit with existing stereotypes including Hall's racialised regime of representation. Dialogic performance analysis encourages multiple readings of transcripts, enabling the researcher to utilise analytic hesitation. In addition, the requirement of the method to locate support for analysis in the transcript and contextual knowledge of the researcher further contributes to Gunaratnam's concept.

5.14 The Research Process

This chapter has outlined the philosophical underpinning to the project, exploring social constructionism and its relationship to both interpretivist and critical theorist paradigms. The development of feminist research, including the importance of intersectional theory in understanding this thesis has been examined and the usefulness of narrative methods from

this perspective, for both social work practice and research are discussed. Critical social work provides a challenge to traditional approaches and attempts to address the power imbalance found in both practice and research relationships.

Dialogic performance analysis is presented as the method of analysis and is related to the theories explored in chapter four. The requirement to complete dialogic performance analysis before conducting thematic analysis to identify common themes is explained, and the use of interpreters is considered, with recognition of the challenges this poses to the method of analysis. The importance of ethics is discussed, with attention to the influence of power, where Stuart Hall's theory of representation is used to address these concerns.

Once the theoretical, philosophical and methodological aspects of the project have been outlined, the practical undertaking of the research task can be summarised. This is compiled below as a step by step process;

1. Contacted community centre, discussed and agreed project could be conducted
2. Gained ethical approval from Manchester Metropolitan University and provided written description of the study and copy of ethical approval to community centre
3. Attended luncheon club and asked members if I could join the group, transparent about research aims
4. Attended club for several months, openly discussed project if asked
5. Explained project to women with support of members who had interpreting experience
6. Asked for volunteers to be interviewed
7. Collected contact details and arranged interviews either with members themselves or via nominated family member
8. Explained information sheet and gained consent from participant and family member
9. Conducted audio-recorded interview (in one interview, audio-recording was declined, written notes replaced this)
10. Saved audio-recording with code
11. Allocated pseudonyms
12. Transcribed interviews using pseudonyms
13. Completed dialogic performance analysis (as described earlier in this chapter)

14. Developed case studies
15. Thematic analysis of case study narratives completed
16. Project written up

Chapters four and five have explored the theoretical position and methodological decisions underpinning this thesis in order ground the analysis in an appropriate framework. The following three chapters present the combined results and analysis, linking back to the theoretical concepts described in the earlier parts of this thesis.

6. Analysis: Case Studies

6.1 Introduction

The analysis is presented across the following three chapters, in line with narrative research methods such as dialogic performance analysis, where it is of fundamental importance to keep the individual narrative together in order to fully explore the participant's perspective in context. Three of the interviews have been chosen as case studies, with a section in this chapter for each. excerpts of text are presented and analysed to illustrate how the method can be used to attribute meaning and develop an understanding of the participants' identity, following Riessman's (2008) example. These interviews were strategically selected as they offered the most extensive narrative accounts, and the most diversity in terms of capital distribution between participants. The selected participants were also those who had experienced the widest variety of English health and social care services. It was in exploring these aspects of the interviews that the value of intersectional analysis becomes apparent.

The second analysis chapter focusses on the unifying themes that were developed across the three case studies, following thematic analysis. Throughout this seventh chapter the narrative accounts of all participants are drawn upon to support the emerging themes. The third analysis chapter (chapter eight) explores the theme of intersectionality in more detail.

Before each case example in this chapter is a summary of the participant, to give context to the extracts of text. The summaries of the remaining participants not presented in this chapter can be found in the table below. Initials are used in the transcript extracts to identify myself (SP) and the participants.

6.1.1 Table 4: Participant details

Pseudonym	Language	Interpreter	Others Present	Summary/Pen Picture
Rehana	Urdu	Neighbour's daughter	Neighbour & neighbour's second daughter	See page 136
Sayida	Urdu	Daughter	Husband	<p>Sayida is a 60-year-old woman who has lived in England for 44 years, she came from Pakistan aged 16 to join her husband who was already living in the country. The couple live in their own terraced house with two of their daughters. In total, they have nine children; eight daughters and one son.</p> <p>Sayida's family home was a regular terraced house in an area with a high Asian population, it stood out from other homes on the street as it had been extended to the front to include a large window and pillars over an ostentatious front porch. Building debris at the front of the house indicated that work had recently finished or was still taking place inside. The home had marble pillars where an interior wall had been removed; chandelier style lights and a huge leather suite filled the room I was led into and the walls were adorned with graduation photographs of the couple's children. After the interview as Sayida's husband showed me out, he pointed out each child and their associated degrees with pride.</p> <p>Sayida had suggested one of her daughters as an interpreter, and I was given a landline number to contact her on to arrange the interview. When attempting to contact her by phone there was some confusion; Sayida had not advised her daughter about the arrangements or the project. After explaining to the daughter, she was happy to go ahead and a meeting was arranged for the following week. The same day I received a call from Sayida's son, who wanted to know more about the project before the meeting went ahead. This was discussed and he was happy with the explanation of the research rationale. When I arrived at the house, a different daughter was present, as her sister (a</p>

				<p>carer at a local care home) had been called into work, Sayida's husband was also present throughout the interview.</p> <p>Sayida had many physical ailments, including high blood pressure, diabetes and an undiagnosed kidney problem, she was also in constant pain with her leg and shoulder, the latter of which had been operated on ten years earlier but never recovered. As a result of the leg pain Sayida was only able to walk a few meters and had been referred to a local hospital for an appointment the following month. She had no knowledge of support services available to her however was receiving a disability benefit. This was a point Sayida's husband was keen to discuss, hoping I would be able to advise them on how to apply for a higher rate of the benefit due to the reduction in Sayida's mobility. The interview was short and it was frequently difficult to ascertain Sayida's opinions as her daughter tended to answer for her without interpreting my questions, despite prompts to ask Sayida for her views. Her husband was very vocal and keen to try and explain his wife's position and frequently asked his daughter what was being said, this often resulted in the family talking over each other and was quite loud on occasion. Both Sayida or her husband had limited English language skills although her husband did have some conversational English.</p>
Yasmine	Urdu	Son	N/A	See page 152
Safina	Punjabi	Son	N/A	<p>Safina was recruited to participate in the research project in a different way than the other women; she had not been attending the luncheon club for some time due to a serious heart condition and recent bypass operation. During one of the luncheon club sessions, her husband approached me and asked about the project, as he had heard from the centre manager I was conducting some research. I described the study and he asked if his wife could take part, I advised that he would have to check that she wanted to be interviewed before I could agree to an interview. The following week the man returned and said his wife would be willing to participate and their son Hamza would interpret for her, an appointment was then made for the following week.</p> <p>Safina is an older Pakistani woman who has lived in England for 34 years, since moving here with her husband from Pakistan, where she was an Urdu teacher. In her younger</p>

				<p>days in England Safina had attempted to gain employment as a translator but was advised she must take English language qualifications before she could apply for such a position. Safina's first language is Punjabi, however due to her teaching background she is able to communicate in both this language and Urdu when she attends the community centre. Safina lives with her husband and one of her two sons in a small terraced house that they own. The home is small and the room I was led to, at the front of the property, housed a push bike and was visibly in need of repair, appearing to be more of a storage space. The property was cold and the son brought a portable electric fan heater to the room before helping his mother to her seat. Safina had very recently undergone heart surgery, a procedure she had experienced several times as part of an ongoing illness. On this occasion, her heart had stopped and she had been rushed into the hospital. She was visibly pale and unwell on our meeting and I asked if she would like to rearrange for another time, continuing only when she insisted she wanted to go on. Alongside the heart surgery Safina also has diabetes and has frequent chest infections due to fluid on her lungs. Of all the women I interviewed she presented as in the most fragile health but was the most complimentary of the support she had been given by the primary care agencies involved in her care.</p> <p>The interview was relatively short, potentially because Safina and her son felt they were unable to contribute any criticism to the services they had accessed. Despite being encouraged to talk more about the positive aspects of the care Safina had received, they felt unable to make a contribution.</p>
Reema	English	N/A	N/A	<p>Reema volunteered to be interviewed after I had been attending the luncheon club for many months. She and a friend approached me to take part at the end of one and Reema explained that she had been unhappy with an event she wanted to share with me. Reema has a good level of conversational English although expressed several times during the interview that she wished her language skills were better, so she could communicate her ideas to me more clearly.</p> <p>Reema was the only participant who declined the audio recording of her interview, preferring me to write down her thoughts, I chose to do this by writing as many direct</p>

				<p>quotations as possible, which meant I had to sacrifice recording as much of my own speech as was possible in the other interviews. The decision not to allow me audio recording can be seen in the recent context of the community centre, where some photographs had been taken of the women during a meeting to use as marketing and had been posted on social media without their consent. In some of these photos the women did not have their veils or niqabs on as they would have if they had known that they would be shared in a public forum. This was a concern that other participants voiced, but Reema was the only one to make this decision.</p> <p>Reema is a 60-year-old Pakistani woman who has lived in the UK for 38 years, she was 22 when she arrived to join her husband from Pakistan. Reema has seven children; five daughters and two sons but lives with just one of her daughters in a large terraced house that she owns on a main road. Reema is proud of her home and her family, she told me that one of her sons had done all the decorating and work in the house for her and had recently carpeted the stairs and cellar to convert it into a playroom for her grandchildren when they come to stay.</p> <p>Although Reema's home was well maintained, she has poor physical health including a heart condition which required two stents implanting in 2012 and an operation on her leg in 2011 which has left her with metal pins and significant pain. Reema is supported by her daughter and daughter in law, who lives in walking distance and comes to sit with her during the day while her daughter is at work. Despite being an animated, warm, and friendly woman, Reema described being very lonely because of the isolation her physical health necessitated. Of all the women interviewed she was by far the most passionate about the discrimination that faces older Pakistani women, her motivation for participating demonstrates this.</p>
Muna	Urdu	Daughter	N/A	<p>Muna volunteered to be interviewed at the same time as a friend. Unlike her friend, Muna was not able to participate without the support of an interpreter and she nominated her daughter Salma to do this. She arranged the interview at the point of volunteering without consulting with her daughter, for the following week and assured me this would be ok.</p>

				<p>Muna is a 61-year-old Pakistani woman who has lived in England for forty years, having arrived to meet her husband who was already here in 1976. Muna lives in a small terraced property in a largely Pakistani populated area of the town, close to the community centre and several of the other participants. She owns the property and lives with one of her five sons following the death of her husband some years ago, she also has a daughter who lives in Bradford. Salma had been staying with her mother for a few days at the time of interview, with her own children, Muna's grandchildren.</p> <p>On arrival at the property I was shown into the front living space, where two of Muna's sons were sitting. Salma ushered the men out of the room, quickly dismissing my objections and suggestion of another room, she also asked the children to go and play elsewhere, closing down any discussion of this with them.</p> <p>Muna is a quiet woman, who suffers with arthritis pain which prevents her being as active as she'd like. She describes enjoying morning walks and peace – of which she seemed to get little in the happy chaos of her home; the children interrupted the interview with various requests throughout the recording, each time being shoed away by their mother. Salma, although she did not disclose her employment, presented as well educated and confident. She was clearly concerned about her mother's health and the distance between them geographically, on several occasions she gave her own opinion before interpreting the questions for her mother to offer an answer. The interview took place close to lunchtime and Muna asked me if I had eaten, and my plans for lunch, checking I was going to eat before returning to my workplace.</p>
Farah	English	N/A	N/A	See page 168

6.2 Rehana

I arrived at Rehana's neighbour Tasleem's house as I had arranged with Tasleem's youngest daughter Ali, to interview her. As I was ushered into the sitting room, Ali told me that her mum was still in bed and stated that their neighbour Rehana had also volunteered to be interviewed but had not heard from me. I consulted the list of names and identified the correct participant. I had in fact contacted her daughter, who had declined to interpret for her mother, citing her childcare and work commitments. I had been waiting for the next luncheon club to discuss this with Rehanna. Without my sharing my information, Tasleem's daughters, Ali and Samera, both passed comment on the lack of input the neighbour's daughter had, appearing unimpressed by her involvement in her mother's life. Ali animatedly decided she would go and invite Rehana to join us and before I was able to consider this fully she had left the house to retrieve her.

Rehana lives alone in the neighbouring house to Tasleem, who I had originally arrived to interview. The homes are joined and Rehana owns her home, which she bought from the council with the help of her only child, her daughter. She has been in England since her teens/early 20s when she moved from Kashmir and was married before her husband passed away. She describes feeling very lonely in his absence, and without a companion in her home.

Rehana is very overweight and suffers with sleep problems, arthritis, back and leg pain; for which she walks with a stick. She has also received treatment for depression, which she is more open about disclosing and discussing than Tasleem. Rehana is a much more outspoken woman than Tasleem generally, and overpowered the conversation from the beginning, discussing her health problems and opinions on the services she had been offered to overcome some of these.

This outspoken nature was also observed in Rehana's attendance at the luncheon club where she was an animated and active member, whose absence was noticeable on the weeks she did not attend. Despite her evident pain on mobilising, Rehanna once told me that she walked to and from the group every week, which was about half a mile from her home, in all weather, which I witnessed on many occasions, seeing her arrive breathless at the weekly lunch club. When Rehana originally mentioned the weekly walk, my gaze

subconsciously fell to her feet and swollen ankles, which were covered in open ballet-style fabric pumps, despite the poor weather.

It was clear from the interaction that Tasleem's daughters were close to Rehana and they easily adapted to interpreting, interchanging this with offering reassurance to her when she became upset and gently mocking her with warm humour on occasions where they felt it was appropriate.

The following four extracts are taken from the interview, which lasted just short of 90 minutes. My words have been included, as have the interactions between Ali and Rehana in Urdu, in keeping with this method of narrative analysis. The extracts are interspersed with my analysis throughout and chronological order has been maintained to keep the narrative sequences together.

This first extract is the first interaction in the interview.

6.2.1 Extract 1

A: she goes; 'they do what they want the doctors, they're not bothered' (laughing)
and when she goes to hospital she doesn't have, what you call, when they...

R: interpreter

A: they didn't come, she booked for her, but they don't turn up, so her appointment gets cancelled and she has to go back when *they're* available

SP: So is that frustrating? Or what do you think would be better?

RandA: Urdu

Ali: Yeah, it is frustrating, because she tries to book a transport so she's paying, she's going there for no point and sometimes she has to go as far as Manchester!

R: Urdu

Ali: *starts to talk over Rehana* so she's got travel expenses she can't afford and she's paying double, to give her appointment today and she's not turned up [she has] to go tomorrow again she's paying double and it's sometimes, she's got to go all the way to Manchester, for appointments.

Me: Erm, do you think there's another way they could manage that?

Ali: She...they could turn up, make sure they turn up, if not, sack em, same as every job (laughing)

R: Urdu

Ali: she turns up to the NHS people, the doctor, she goes it's not a problem to come, if not, just cancel the appointment.

In this first section, Ali recounts the first of Rehana's experiences of poor care from the interpreting service at the hospital. From the very beginning of the interview we are introduced to the boundary at which Rehana's identity is formed; her very first word; 'they', introduces us to the idea of the other, a theme that reoccurs throughout the interview. In this exchange, 'they' is clarified as both 'the doctors' and 'the NHS people', an interchangeable genderless group 'other', who routinely behave unprofessionally; 'she, they could turn up, make sure they turn up'. At the beginning of this sentence we see Ali quickly self-correct, from 'she' to 'they', indicating a switch from referring to one specific incident, with a gendered 'other' to a generalised response to a more common experience of poor practice which is clarified in the next excerpt. This ill-defined, generalised other can be contrasted with the specific 'other' described in different parts of the interview where a positive interaction is described, for example; 'the Indian lady'.

Against this other, Rehana positions herself firstly as struggling financially; 'so she's paying'... 'she's paying double... she's got travel expenses she can't afford and she's paying double' but also as a reasonable woman, a 'good patient', gracious even when faced with poor treatment; 'it's not a problem to come'. This last sentence contradicts the focus of the interaction, which describes the financial and practical challenges involved in attending the appointments, presenting Rehana as both recognising and accepting of this poor treatment and allowing her to position herself as a passive recipient, at the mercy of the 'other's' treatment.

Rehana orientates herself in space and place in this first interaction. The geographical location of the appointments is described as 'as far as Manchester' and 'all the way to Manchester', when describing a hospital that is approximately ten miles from her home. The financial and practical challenges already recounted contribute to the positioning of this location as so far away and allow Rehana to maintain the role of a 'good patient', going to such trouble to meet the demands of the 'other'. Although the physical distance to the hospital is not an unusual distance to travel for a consultant appointment, for Rehana, the

combination of challenges to get there, mean that she sees it as outside of the space and place she is comfortable with.

This first excerpt of the interview is interpreted entirely through Ali, and we can start to identify features of her language alongside Rehana's words. Riessman encourages analysis to identify repetition within transcripts. As such, the repetition of the phrase 'she goes' in this and following sections of the transcript can be understood as Ali's way of indicating that she is recounting Rehana's perspective, as the term frequently follows an interaction between the two in Urdu. We also see one occasion where Ali begins to talk before Rehana has finished, evidencing the co-constructed nature of the narrative, her familiarity with Rehana's life, and her impatience and enthusiasm to get the words out as soon as she hears them.

The interaction between the two is a dialogically constructed one, with Rehana offering the term 'interpreter' to Ali, when she struggled to identify the word. We later hear that Rehana can understand English language, a point evidenced here and throughout, where she offers contributions in English. This also adds credibility to Ali's interpreting, as Rehana demonstrates the confidence to interject when she feels misrepresented.

In Ali's sharing of Rehana's words, 'if not, sack em' followed by a shared laugh between the two, we can see the strength of their relationship with each other, in sharing a joke, but also their recognition that suggesting that the hospital interpreter, the elevated 'other' should lose their job is a bold statement in front of me. This statement both contradicts the 'good patient' identity that Rehana has presented and also suggests their nervousness at expressing this daring opinion to a fellow professional (me). Goffman's work on performance allows us to explain this interaction as the pair allowing me access to their backstage or 'back region'; they are reading my 'sign equipment' or social cues and feel able to let their guard, or 'front' drop. The laugh also indicates that this statement is a joke, however in the final excerpt we see a more earnest return to this idea.

By the end of this first, generalised narrative of poor care, Rehana is clearly positioned as embodying a 'good patient', aware and accepting of, but prepared to make financial, practical and emotional sacrifices to meet the requirements of a faceless, and disrespectful 'other'.

As we move through the interview, Rehana returns to, and expands on the generalised incidents of poor care in the first extract;

6.2.2 Extract 2:

A: She's had four separate occasions where twice they've not turned up and she's gotta come home, and then this one time she was er, badmouthing her to the doctor cause the doctor tried to tell her something about inside intestines and the translator she er she goes 'oh she doesn't know, they're illiterate people, she won't know what you're trying to say'

SP: She was badmouthing the doctor? Or...

A: no her!!

SP: Oh!

A: To the doctor, saying 'she won't understand what you're saying' but she understands, she just can't speak back.

SP: that's shocking

R: Urdu

A: She goes, she goes at, at one time she went for a head x ray, and she was speaking to, she was trying to translate to her, cause she didn't understand so she told her to repeat herself, she goes to the doctor she goes 'she says she speaks Urdu but she doesn't really understand me'

R: Urdu

Al: *over the top of Rehana* The doctor and, the doctor and the translator started laughing so she felt like really down and embarrassed

SP: that's awful

R: upset Urdu

A: and she doesn't know how to ask, and she goes on public transport, and she's got language barrier and that causes a lot of problems like, she goes there she gets frustrated more, yeah, that.

SP: do you think that stops you from wanting to go?

AandR: Urdu

Ali: yeah, cause the doctors even make her feel like unwelcomed and *quiet voice* she doesn't feel like going.

In this section we hear of two occasions where Rehana has travelled multiple times to an appointment, only to find that no interpreter is available to support her. This is followed

by two specific narrative accounts of appointments that have gone ahead. These specific incidents are then tied in the final narrative, to the multiple additional issues that Rehana has faced in order to attend the appointments (repeated from the first excerpt), with the combined impact felt as one.

The only speaking roles in this section are given to the interpreter, identified as 'she', with 'the doctor' remaining genderless, and in the final section being generalised to 'the doctors', demonstrating that the detrimental impact of these interchanges on Rehana's identity are generalised across all encounters. According to Riessman (2008), the allocation of speaking roles within a narrative is a linguistic device used to indicate importance.

On both occasions we hear the interpreter's negative positioning of Rehana; 'oh she doesn't know, they're illiterate people, she won't know what you're trying to say'...'she won't understand what you're saying', then in the second incident; 'she says she speaks Urdu but she doesn't really understand me'. In this first encounter, we see the interpreter make a generalisation from Rehana as an individual, to a more generalised assumption about 'they' being 'illiterate' in the face of being asked to relay some more complex medical information. Having an awareness of the context, this 'they' can be attributed to people from the area of Kashmir that Rehana originates from. Kashmir is a poorer province of Pakistan, with the majority of those having migrated from this area to England being from agricultural backgrounds and having accessed little formal education before or after moving to England. This contextual understanding enables us to locate the earlier generalised disrespect as class-based discrimination from the interpreter. This is then extended in the second encounter, to undermine Rehana's self-identified first language. 'They' is also used here by the interpreter as a way of separating herself from this underprivileged group, challenging any assumptions the doctor might have of shared heritage and elevating her own position.

In both of these interchanges, the interpreter places blame on Rehana for their difficulties in communicating; in the first the interpreter positions herself as expert on Rehana and those who share her place of origin, and in the second advises the doctor that it is Rehana that 'doesn't really understand', not that she is unable to communicate with her. Following these two narratives, we could presume that the discriminatory behaviour is limited to the interpreter, maybe in an attempt to present an elevated self-identity, however, we see this

followed up with the revelation that the doctor and interpreter ‘started laughing’ at this shared understanding of Rehana’s circumstances.

The impact of this poor and discriminatory treatment is evident; Rehana feels ‘really down and embarrassed’, ‘really dep, frustrated’ and ‘doesn’t feel like going’. These feelings are compounded by the challenges already facing Rehana in travelling to the appointments, which are repeated at the end of this section from the previous extract. The impact is not only evident in what Rehana says, but in her inability to challenge these incidents, she previously suggests ‘sack em’ as a response to the interpreter’s non-attendance, but when the opportunity is presented she recognises the privilege of elevated status, of ‘NHS people’, and is silenced by this unspoken power hierarchy. In the face of this explicitly discriminatory behaviour, Rehana still performs the ‘good patient’ identity, not challenging this negative description of herself, instead internalising it. Even in our interview, it is Ali, not Rehana that confronts this identity; ‘but she understands, she just can’t speak back’. We understand this as Ali, from her own knowledge of Rehana’s language skills, as there is no exchange between the two in Urdu before this interjection, nor does she begin with her favoured prefix; ‘she goes’.

In this section we see Ali’s jovial presentation change, to mirror Rehana’s emotive narrative, her voice is quieter, and there are no shared jokes as we hear much more serious narratives. The repetition of ‘the doctor, the doctor’ over the top of Rehana’s speech shows her enthusiasm to relay the message remains. Having heard my response to the first narrative ‘that’s shocking’ she is now aware that I will be equally outraged by the information she is about to share. Again, Ali self corrects mid-sentence in the final part of the extract ‘really dep, frustrated’, stopping herself from saying ‘depressed’. It is unclear at this point why she refrains from this word choice, but later we see a possible explanation, as Rehana has received services to support her with a diagnosis of depression.

My contribution ‘that’s shocking’ halfway through the section of talk contributes to the direction of the narrative, demonstrating the co-constructed nature of the content. Hearing that I am sympathetic to Rehana’s situation, the narrative continues to expose the practitioners, with Rehana disclosing more unprofessional and discriminatory behaviour.

At the end of this section, Rehana has positioned herself as a passive recipient of some very discriminatory care practices, who overcomes significant obstacles to attend necessary appointments for her health, only to have her identity as an Urdu speaking Pakistani woman challenged and mocked by the very person employed to support her to communicate. This is an unfavourable position to present herself in, but Rehana sacrifices the 'preferred identity' for the 'goal orientated identity' here; by presenting herself as a vulnerable, passive patient, she positions the doctor and interpreter as purposefully discriminatory and oppressive.

6.2.3 Extract 3

In this section of talk, Rehana raises her concerns about social workers in relation to space and place. Where in the first and second extracts, the challenges of travelling to appointments situated outside of a constructed safe space or comfort zone, here Rehana prioritises some of the problems she perceives with support that is located within her 'community'.

A: she goes get a social worker from out of town because if you get, if you get from Xtown* they know you and in the community, they go and talk to someone else about it.

SP: you mean if it's someone from the community that's the social worker you think they might tell other *tails off*

A: she goes she's had that experience where she's, not had, not had result but she's seen someone talking about someone...

SP: right

A: so it's not private and confidential is it? They're going against their job...
animated I should become a social worker!

**Text removed* discuss social work role and qualifications needed etc.*

A: she goes she heard them on the bus and they be talking about someone 'she said this and she said that and she's got this problem'so it's not like

R: *in English* one English girl and one Asian, together sat behind me was talking to her *giggles*

SP: ohhh and you knew the woman they were talking about?

R: yes

A: *laughing*

R: Urdu

A: she goes if it's out of town you don't know, they can say what they want but at least they don't know her *laughs*

**Xtown is used as a pseudonym for the name of the research area*

The section starts with Rehana positioning herself as knowledgeable in this exchange, she is telling me, the researcher, in the present tense, what I should do if I want a good service, indicating that what she has learned from the exchange she witnessed can be generalised to all social workers. In this exchange the term 'town' and 'Xtown' are used interchangeably to indicate her 'community' or safe space and place. In another section of the interview, Rehana refers favourably to a counselling service she has attended in another part of the Xtown, there she identifies the neighbourhood by name, therefore indicating the difference between the counselling service location and the interchangeable 'town', 'Xtown' and 'community' in this exchange.

A presumption could be made about Rehana's assertion that 'they will know you'; that she is implying she would be allocated a Pakistani social worker, however, as we read further, she clarifies this, stating 'one English girl and one Asian'. This clarification acknowledges that the ethnicity of the worker is less important than their geographical base, but also indicates a lack of understanding of the adult social care system. Social work services are provided from the local authority in which one resides, meaning Rehana would always be allocated an Xtown based worker. Despite this misunderstanding of the system, and despite her awareness of my own professional background, Rehana positions herself as knowledgeable, laughing about this incident as if it is a well-known 'fact' within the 'community'. This has implications in relation to the type of 'knowledge' that is shared within the 'community' and the impact this may have on accessing services.

The ethnicity of the workers is identified in English by Rehana, privileging it above other information that she passes through Ali. This use of English indicates Rehana's confidence in the information she provides, but also her confidence in general. The earlier extracts focused on Rehana's own negative experience, returning her to the scenarios where she had felt undermined and embarrassed and where she had been discussing her inability to communicate in English. In this exchange she presents her more confident self, removed

emotionally from the content of the conversation. This excerpt allows us to see how Rehana's identity performances adapt, dependent on how she is positioned in relation to 'others' in the exchange. When she is enabled and encouraged to share experiences and can guide the focus of the exchange, Rehana is able to contribute, and find humour in the scenario she describes.

The final sentence in this extract, Rehana's words interpreted by Ali add to the negative perception of professionals already presented in earlier sections; 'if it's out of town you don't know, they can say what they want but at least they don't know her'. The words return us to 'they' as a generalised professional other, in this case social workers, and the assumption that the breaches of confidentiality will occur, whether the worker lives in the local area or not, but that it is better that this breach is shared with strangers than with those in the local community. This shows us simultaneously that maintaining a positive image is very important within the 'community' and that threats to this are taken very seriously but also demonstrates a blanket mistrust of professionals. This idea that left unchecked, professionals will behave unprofessionally is returned to in the following case studies, and across the interviews generally indicating a system of representation has developed (Hall 1997). The shared laugh at the end of this sentence again shows us that this issue is taken for granted, and not concerning to either Rehana or Ali, this contrasts with the shift in tone Ali utilised when relaying emotive content.

There is a visible distinction in the language used between referring to events that have a negative impact on identity and more positive events relayed in other parts of the interview. Negative events appear to use a generalised 'they', where 'the Indian lady' at a group counselling session, a positive experience, is given both a gender and ethnicity. This can be seen as Rehana indicating her assumption that negative events are a default, whereas more positive interactions are seen as a 'one off', and are given more description, before returning to a generalised 'they' for later sections of text. This low expectation of professional's behaviour reoccurs throughout the interviews.

Ali returns to her animated self from the first extract in this section, smoothly transitioning from the empathetic self of the previous excerpts. She sees an opportunity here to present herself in a favourable light and guide the conversation, initially by proudly stating 'its not private and confidential', showing her own knowledge of confidentiality rules. This is

followed by the statement; 'I should be a social worker!' performed for me as a researcher with a social work practice background. We can understand this attempt to position herself positively as attributed to both Ali's youth and her perception of me as in a position of power and privilege. This fits with her frequent repetition at the start of interpreted sentences 'she goes, she goes', where she appears bursting to get the information she holds out into the open.

We see the continuation of 'she goes' as the preferred prefix to show Ali relaying Rehana's meaning, which is contrasted with excerpts (not shown) where she speaks on behalf of her mother, who she tends to answer for, rather than interpreting my words to and vice versa. This reassures us that despite Ali's enthusiasm to present herself favourably, she continues to interpret Rehana's words.

By the end of this excerpt we have a contrast, between the self Rehana presents when positioning herself in interaction with medical professionals, where she is emotionally involved in the narrative, and the self, presented when she is confident in the knowledge she possesses and is emotionally detached from the narrative. We learn more about the way information is shared between the 'community' members about professionals, and about the low expectations of their behaviour is generalised, with good experiences being individualised as isolated events.

6.2.4 Extract 4

This section of the interview returns us to the narrative of poor experiences, with Rehana relaying a story of her time as an in-patient at hospital following an admission for two operations. This is the longest narrative of the interview;

A: she was still in hospital for seven days after her operation and she had no help from the nurses whatsoever, they never came cause, I think..

AandR: Urdu

Ali: she had a couple of operations at one time and they never came up to her like to ask if she needed help, brushing her teeth or going toilet or anything, so she just laid there all day

Pause

SP: why do you think that was?

A and R: Urdu

A: she goes, there's more, there's help

R: Urdu

A: she goes, they was nice to the others, helped get them up, brush their teeth and everything but with me they never bothered with me

R: Urdu

A: and the doctor used to come, that's the only time they used to come, with the doctor trying to be like, be nice to her

R: Urdu

A: so she used to look at them and she used to feel more depressed thinking why they being nasty to me and...

R: *upset*

SP: that's not a good experience to have

R: Urdu

A: she goes, people used to get visiting, and peoples get four or five and then when she used to get two to three people they used to tell people to get out

R: Urdu

A: yeah she was only allowed two visitors when the rest were allowed four five

SP: do you have an idea about why you might have been treated differently?

Aand R: Urdu

A: she said maybe because she's racist.

R: Urdu

A: she goes, because she was the only one there that wasn't white, all the rest were white

R: Urdu

A: I mean she said she never used to bother them, if they never used to come she never used to call them.

SP: did you not feel confident to ask them for help?

A: no because she never used to feel comfortable because they never used to give her good feelings

R: Urdu

A: yeah she didn't want to complain to the doctor, because she goes there's no point because it effects their job so there's no point complaining

SP: how do you mean 'it effects their job'?

A: she goes they could lose their job if she complains

R: Urdu

A: and she goes if she complains because they're not good they could get sacked

From the first sentence in this extract we see a return to 'they', in this narrative this is clarified as 'the nurses', who are not given any further identifying characteristics throughout, nor is 'the doctor' who also appears. The other patients around Rehana are identified only as 'the rest' with their only identifying features being their whiteness, as this is seen by Rehana as the key characteristic separating her from 'them'.

Through Ali, Rehana describes the poor treatment she receives from the nurses 'they never come up to her...they never bothered with me' and sees these acts as purposeful; 'why (are) they being nasty to me' is spoken in the present tense as she relives the experience, becoming emotional. Although Rehana describes being ignored, she sees this as an act rather than as a lack of action, as she did not receive what she perceived to be equal treatment or support to the other patients on the ward. Clear examples are given; 'brushing her teeth' is repeated twice, along with 'going to the toilet'. Rehana associates this act of ignoring to another experience, where she perceived herself to receive unfair treatment in relation to her visitors, with 'the rest' (white patients) being allowed more visitors and hers being told to 'get out'.

In this extract, in response to the treatment described, Rehana returns to the presentation of herself as a 'passive recipient' of poor care in contrast to the confident woman laughing and telling me about social workers in the extract above. Not only does she describe not being confident to ask for the support she required because 'they never used to give her good feelings', but her actions position her as passive; 'so she just laid there all day' and 'she never used to bother them'. The latter statement particularly positions Rehana as what she understands to be a 'good patient', not 'bothering' the nurses, or acting in a way that would cause them to respond negatively to her.

Rehana internalises the treatment she receives, making her 'feel more depressed', a word that Ali earlier faltered at using, and self-corrected, but now, further into the interview and after a discussion of the counselling Rehana received for depression, she is confident to use it. The treatment by the nurses causes Rehana to reflect on and question herself, considering why they were 'being nasty' and confirming that she 'never bothered them', almost convincing herself that she was not to blame.

When asked why she thought she had been treated differently Rehana states 'maybe because she's racist'. This is the first time the nurse's gender had been identified as 'she', and the statement is in present tense 'she's racist' – she *is* racist, not she *was* in this one-off incident, but she *is*, indicating what Rehana perceives to be the fixed position, racism, embodied in the nurse. Although this statement indicates that Rehana is unsure that this is the reason with a 'maybe', she then evidences her claim by identifying the whiteness of the other patients, repeating 'white' twice in the short sentence to indicate the importance of this feature.

Interestingly Rehana is able to identify the performance of the nurses when positioning themselves in relation to the doctor and performing their 'preferred selves'; 'trying to be like, be nice to her' and performing the role of a 'caring nurse' only in the presence of someone with a higher position in the hospital hierarchy. Rehana exposes the nurse's performance here and perceives it as fake, moving directly from this statement to describe how their 'nasty' behaviour made her feel 'more depressed'. The connection between what Rehana perceives to be an act of deception on behalf of the nurses and the impact on her emotional state supports the idea that the treatment lack of attention she received was a purposeful act, as this behaviour was altered in the doctor's presence. It appears to be the purposeful nature of the racist behaviour that has the most impact on Rehana.

In the final section of the extract we see a return to an earlier theme, as Rehana describes not reporting the poor behaviour of the nurses because she didn't want them to lose their jobs. This contradicts her initial 'sack em'' response to the hospital interpreter repeatedly failing to attend her appointments which was followed by a shared laugh between Rehana and Ali, indicating that this was a joke. Here, in contrast, Rehana offers a more serious position on complaining about poor service, without being prompted. Although Rehana, via Ali, identifies that the nurses in question may lose their jobs if she complains, the

repetition of the phrase 'there's no point' seems to contradict this assertion that they may be 'sacked', as this was seen earlier as a fitting punishment to a lesser charge of non-attendance. 'There's no point' could also relate to Rehana's positioning as passive in these exchanges with health professionals, and her perceived position in relation to the doctors and nurses in the medical hierarchy, recognising that she is unlikely to influence the nurse's employment or racist opinions more generally.

Rehana's experiences in the earlier extracts have shaped her identity in relation to the 'NHS people' as of little value. She has experienced disregard for the challenges she has overcome to attend appointments, non-attending professionals, mockery, had her care needs overlooked and been treated less favourably than white fellow patients. In addition, she has heard professionals discussing people she knows on public transport. We see that when interacting with 'them', Rehana performs the role of a passive recipient, recognising that the professionals that should be caring for her are providing a poor service, but accepting this position in the hierarchy. She internalises this treatment, and, as we see in the three extracts involving her care, she becomes upset when discussing this, embarrassed to admit the racist nature of the interactions, and unable to challenge 'them', as they are all part of one 'NHS people' who openly discriminate against her.

This passive care recipient identity is contrasted with the self that is performed when Rehana is confident and comfortable. Here she uses her English language to guide the conversation, and to interject with key information, she jokes about the 'community' attitude to professionalism, and about 'sacking' interpreters that don't show up, laughing as she is comfortable to cast judgment from the safety of her neighbour's home. This is the self that is presented at the luncheon club, amongst friends. We can see the former self, as exposing intimate and upsetting details of her poor treatment, and positioning herself as weak and helpless, in order to accurately present 'them' as she sees them; discriminatory and unprofessional. Rehana allows me access to this self, as I have spent time as an individual, attending the luncheon club, and performing my individual self, as supportive and understanding. Rehana is also aware of my 'professional self' as a former social worker in the area, with a cultural awareness of the local issues, and in a position of relative power, as a researcher, to expose the treatment the narratives offer.

6.3 Yasmin

Yasmin is a 60-year-old Pakistani woman who has lived in England for over 40 years. She lives alone in a small semi-detached council property across the road from her only son, who is in the process of buying the property for his mother. She also has three daughters and several grandchildren; her front living room has many young children's toys in one corner.

When she volunteered to be interviewed Yasmin requested her son Mohammed be the interpreter for her as he lived closest to her. When I contacted Mohammed to arrange the interview, Yasmin hadn't informed him of the research project but once I explained this he appeared keen to arrange an appointment for an evening the following week.

When I arrived at Yasmin's house her son was not yet home, Yasmin stated that she could tell he wasn't home as his car was usually parked in front of his house, and she could see this space from her window. Although Yasmin described her language skills as poor, she was able to make conversation and we chatted about her grandchildren and my own son, with her enquiring about who was looking after him to enable me to visit in the evening. Yasmin also spoke about her son, how much he helped her and pointed out decorating and home improvement tasks he had completed for her, as her mobility had declined recently. When Mohammed arrived, he explained that he had been held up in the supermarket, before enthusiastically offering me a variety of drinks and snacks.

Throughout the interview the relationship between mother and son was very close, with the pair exchanging long periods of laughing and joking in between responding to my prompts. Mohammed had very good English language and intimated several times that he was viewed as a person of good standing locally. He told me of a friend's involvement with children's social work due to a difficult divorce and was aware of recent changes to free legal representation rules. Despite this, the pair reported having very limited knowledge of adult social care and the potential services Yasmin could access during the interview.

Yasmin has arthritis, which she described as affecting her ability to do everyday tasks around the house, she did not identify any further health issues although during the

interview did discuss her current attendance at a mental health support group and previously seeing a psychiatrist.

The first extract from the interview is the first narrative account that Yasmin and her son present. They describe an incident that occurred whilst attending a recent appointment with a doctor at their local GP surgery.

6.3.1 Extract 1

M: she goes, the majority of its ok, but there was one that we er, we had a doctor recently, his name was Dr Hussain from the Ztown* health centre, and what's happened basically he put some injections in my mother's knees, I was there at the time, but he started like, obviously she went with pain to him,*raised voice* he started shaking the knees, I said 'what you doing? She's in pain', 'that's so the medicine will spread' but ain't ever heard of anything like that, medicine spreads.

Y: Urdu

M: then he made it very worse, the pain went very worse, very worse – really bad, put it this way her knees like they're just like stiff, she couldn't walk, she couldn't pick herself up she couldn't sit down she couldn't lie, nothing at all! Yeah, and that took, that was a good...

Y: Urdu

M: yeah and since then it's got really bad

SP: so it's been worse since the injections?

M: yeah it's been really bad and it's just like steroid injections, she's had em before as well and she's never experienced anything like that

SP: ok, and was this a different doctor than you'd usually have?

M: a different doctor yeah.

Y: Urdu

M: they've just changed them recently, and it was really bad, really bad, and we had to change the doctor because..

Y and M: Urdu

M: yeah

SP: so you've changed your doctor since then?

M: since then, yeah

Y and M: Urdu

M: yeah but it makes no difference now though because she won't have the injection *chuckles to mum*

SP: that's awful

M: yeah it's just like treating the patient like an animal, he starts just like shaking the knees like 'what you doin?' I said to him 'what *are* you doing?', 'you don't shake the knees like this!' You know, I've done a bit of health and safety myself but that was just *ridiculous*, injection it just goes into the system and spreads, it's a *liquid*

SP: mmm

M: yeah 'what you doin'', 'oh you have to', 'please, if you don't mind, stop shaking her', I goes 'do your job man', I go get her, I told him there and then that, *raised voice* she started crying, yeah!

SP: oh no

M: she's had em done before and that's never ever happened before

SP: ok

M: he's not a doctor, not a human doctor anyway, he's an animal doctor! So we totally dis..disowned the person and went to a different doctor!

**Ztown – Local area*

The lengthy narrative here is presented by Yasmin's son Mohammed, who is also Yasmin's escort to all her appointments. Their relationship and the co-constructed nature of the interview is evident throughout, at some points it is difficult to distinguish whose perspective is being presented, and Mohammed can be seen to prioritise his own impression management in the interaction over relaying his mother's words. Because of this relationship, the separate identities are much more interwoven than in Rehana's case study, where a neighbour's daughter who had not witnessed any of the events retold in the interview and had less of an emotional connection to the participant, interpreted her words.

Initially we see Mohammed use the same prefix as Ali when interpreting his mother's words; 'she goes', however this occurs much more infrequently throughout the transcript, indicating that Mohammed often rephrases and adds his own perspective to the experiences his mother identifies. This is expected as he is present for all the incidents described. There are many occasions (included in the transcripts) where Yasmin and Mohammed converse in Urdu, before Mohammed relays a section of talk, suggesting that despite rephrasing, he is also including his mother's words or perspectives.

From the very beginning of the extract we identify that this is an account of poor care, where Mohammed very clearly identifies the doctor and the surgery by name and the doctor is ascribed a gender from the start. Both Mohammed and the doctor are given speaking roles in the re-enactment of the appointment, which is relayed in the historic present (shown in italics here); 'what (are) you doing...*she's* in pain', and the doctor's response, without a conjunction to identify which of the two men is speaking; '*that's* so the medicine *will* spread'. The level of detail provided in this account show that this has been an important encounter, but also that it is seen as a one-off experience, rather than a generalised account of all doctors and the care they provide. The 'he' in reference to the doctor is not generalised to 'they' in the way Rehana generalises her experience to all 'NHS people'.

In this first narrative account we see Mohammed position himself as knowledgeable; 'I ain't never heard of anything like that, medicine spreads', a position he returns to throughout, and presents his 'preferred self', as a dutiful and caring son, who is outraged at the doctor hurting his mother. The appointment described was recent and the impact on Mohammed is still evident as he raises his voice several times when repeating his own words from the interaction. In positioning himself in the interaction, Mohammed also positions Yasmin and the doctor, with Yasmin described in terms of her inability to do anything following the appointment; '...nothing at all'. This positioning of Yasmin as helpless and completely dependent can be seen as a 'goal orientated self' being presented, as although the focus is on Yasmin's vulnerability and weakness, it also serves to position the doctor as the source of her current condition. The repetition of the words 'very and worse' show Mohammed reinforcing the doctor's position as the villain in the narrative, who treats Yasmin in a way she has 'never experienced' before, leaving her in pain and helpless.

The story is presented almost as a fictional fairy tale, where the alpha male hero saves the helpless patient from the villainous doctor. This metaphor is extended in the later sections of the excerpt where Mohammed refers to the doctor's actions as 'treating the patient like an animal', undermining his professional credibility; 'he's not a doctor, not a human doctor anyway'. This extreme response is presented in a series of direct quotes, set in the historic present, with Mohammed increasingly presenting himself as defending his mother.

In these later sections of the narrative we see a return to the incident being separated from Yasmin as an individual; Mohammed again refers to treating 'the patient' as a generic anonymous character. This separation facilitates the presentation of the doctor as a 'bad doctor', with the blame located entirely with him, indicating he would treat any patient with the same poor practice. Where we saw Rehana question her own actions and internalise her poor treatment as personal to her because of her status as an older, Pakistani woman who could not speak English and was from a poor region of Pakistan, there is no such internalisation of this identity for Yasmin. Instead, Yasmin is positioned as an innocent victim of a rogue doctor, with her physical ailment as the only reason for her helplessness in the scenario. Mohammed's attribution of blame away from Yasmin can be seen as a protective factor in defending Yasmin's identity from the impact of intersectional oppression and also representative of the social and symbolic capital he possesses. Although we hear that Yasmin cried from the pain of the treatment, this is different to Rehana's tears, that came from the recognition of her lack of value in the eyes of the 'NHS people'.

Mohammed is again able to position himself as knowledgeable, and as a good son, performing this via his aside to me as a researcher; 'I've done a bit of health and safety myself' in between the direct quotes from the incident. This identity is presented in the context of Mohammed's role in the family, his father has passed away and he is the only male in his family of three sisters and his mother. His use of 'please, if you don't mind' contrasted with 'do your job man!' shows Mohammed struggling to remain in the performance, trying to retain a sense of calm and control by using manners, but also angry at what he perceives as an assault on his mother, who he is self-assigned protector of. Although in the later sections of talk there is no exchange in Urdu between Mohammed and Yasmin, so we can presume this is Mohammed's perspective on the appointment, we can acknowledge that Yasmin originally raised this interaction as important, giving us an understanding that it has had an impact on her, as well as her son.

Throughout the re-telling of the appointment there is reference to Mohammed and Yasmin as a combined 'we'; from the very beginning Mohammed refers to the pair in this way; 'we had a doctor' despite the focus of the appointment being of Yasmin's experience of poor care. This presentation of a shared identity continues in the decision to change doctors as

a result of the incident ‘we had to change doctors’ and ‘we totally dis...disowned the person’. This co-dependence is revisited throughout the interview, enabling Mohammed to assume a ‘protector’ position, with Yasmin’s helplessness reinforced as a side effect of this performance.

Interestingly, despite Mohammed’s positioning of himself in this way, the response to the poor treatment Yasmin receives is not to challenge this via a formal route. There is no mention of a complaint, rather, the pair see no choice but to change doctors; ‘we *had to* change doctors’. This is followed by revealing that despite the change, Yasmin as refused the treatment since the incident, even though she has received the treatment previously with success. Following this information Yasmin and Mohammed share a laugh, indicating they find humour in this act of defiance, creating a sense of ‘us against them’ and privileging this stand against the doctor over Yasmin’s need for the pain relief. This stubborn move is an almost childlike response, but also shows that although Mohammed positions Yasmin as powerless and dependent, in this act of refusal, she has control. This move can also be seen as Mohammed conceding that the capital he possesses does have limits, and that the privilege this entitles him to doesn’t compare to that of the professional.

By the end of this narrative we see the interdependence of Yasmin and Mohammed’s identities, with Yasmin dependent on Mohammed for practical support and Mohammed positioning himself as the self-appointed protector of his mother. The retelling of the appointment and the attribution of blame to a rogue doctor means that the impact on Yasmin’s self is internalised to reinforce her identity as helpless, but not as a result of intersectional oppression as Rehana’s experiences are.

6.3.2 Extract 2

M: *Laughing* she goes, basically she says like, she’s been going to this new one now recently, it’s called ‘healthy minds’ and it’s in erm (asks mum) ... Ztown, I’ve taken her Ztown twice now (checks with mum) yeah twice she’s been twice and erm she’s she’s she’s kind of experienced like they have an interpreter but the family members are not allowed to sit inside so she doesn’t like that

SP: okay

M and Y: Urdu

M: she says she doesn't like that because they told me to go out because it's something to do with healthy minds... counselling! That's it!

removed text

SP: so why don't you like it that it's a different interpreter?

M: no there's always an interpreter, it's just that she doesn't like me sitting outside

Y: Urdu

M: cause normally whenever she's gone anywhere it's either like I will always been there and looked after her you know, see what they're saying, what they're doing, maybe if they did something right, something wrong like cause in the past she's had experience with doctors that they've ended up; doing something wrong and since then she's been afraid

SP: Right, so when was this that people have, is this the experience you were talking about before

M: yeah, the knees one. So since then she won't, she won't like go anywhere unless I'm there.

In this extract we are presented with a narrative about Yasmin's attendance at a group counselling session, this is the first of two mental health services we hear that Yasmin has accessed despite neither her or Mohammed identifying this as a health issue when asked at the beginning of the interview. Although it is not a clear indication that mental health is not attributed the same value as physical health, in the later extracts more evidence relating to this issue is presented.

The interaction begins with the term 'she goes', indicating Yasmin's input into the narrative, however this is followed by the words 'basically, she says', perhaps alluding to the fact that Mohammed has refined the content of his mother's words for the audience.

The next sections of talk by Mohammed follow exchanges between him and Yasmin in Urdu, indicating her input as more substantial here. When asked about the service, Yasmin directs the conversation away from herself, declining to comment on her mental health, and instead raises the issue of using a formal interpreter. There are several clarifications during the dialogue, initially these appear to indicate Yasmin is aggrieved because her son is not able to stay and interpret for her during the session, but on closer examination of the transcript we can evidence another understanding;

'family members are not allowed to sit inside and she doesn't like that'

‘She doesn’t like that *because they told me to go out*’

‘it’s *just* that she doesn’t like me *sitting outside*’

Closer reading of the text clarifies that what Yasmin is unhappy with is the fact that Mohammed is ‘told’ to sit outside and wait, not that she has to use a formal interpreter, this is confirmed by the assertion that ‘there’s always an interpreter’ indicating familiarity with the procedure. Here Yasmin appears to prioritise the preservation of Mohammed’s preferred self, uncomfortable with him being reduced to sitting and waiting outside, having been told, not asked, to leave the room, as this directly challenges his position as a man of influence. This exchange reinforces the understanding of the pair’s identities as co-dependent but also, as the text is more informed by Yasmin’s words than other sections, we see Mohammed unintentionally expose his mother’s attempts to preserve his performance to the audience.

In the final section of this extract Mohammed gives more detail, rationalising his mother’s unease and there is a change from the theme presented in Yasmin’s words above, to focus on Mohammed’s role in ensuring his mother’s experience is positive. We see Mohammed present the idea that without him overseeing Yasmin’s treatment, professionals would default to poor care, this is a theme also present in Rehana account of her experiences. This presumption of poor care is linked to Yasmin’s previous experiences of doctors ‘doing something wrong’ and, unlike the previous extract, this idea is generalised to the focus of this interaction, a group counselling session, from experiences with ‘doctors’. Mohammed uses the plural to describe ‘past experience with *doctors*’ showing the generalisation across both professions and numerous experiences. The final sentence in the extract sees a return to the first story, with Mohammed making a link between ‘the knees one’ and his mother not going ‘anywhere unless I’m there’, however this link to a specific occasion is only made following my prompt, indicating a more generalised concern.

In this interaction we see the role of the family member in appointments presented as more than a practical one to facilitate communication, but as an advocate or guardian, ensuring good practice, indicating that the formal interpreter could not be trusted to take on this more personal role. This understanding of the formal interpreting role mirrors

Rehana's experiences, where without a family member present, the NHS appointed interpreter actively influenced poor practice.

Yasmin's choice to prioritise the preservation of her son's identity performance, and Mohammed's choice to prioritise his mother's safety and his role in maintaining this, are not necessarily conflicting; both of these ideas are important, but the narrative that is chosen by each of the pair indicates that they both privilege the wellbeing of the other before themselves. This further indicates the importance of exploring the co-constructed nature of both the text, and the co-dependence of identity in this relationship. In accepting this interpretation we see that although Mohammed positions himself as his mother's protector, she is also protecting him by enabling him to maintain this performance, demonstrating that she does have some power and control, even though this is not recognised by her son.

At the end of this extract we see Yasmin is unhappy with the group counselling service, due to the requirement to use a formal interpreter, not because this in itself is unsuitable, but because of the implications it has for Mohammed. We also see links with the previous case study in the generalised presumption that professionals will default to poor care practices if not supervised by an advocate or guardian, and that formal interpreters are not trusted to take on this role.

6.3.3 Extract 3

M and Y: Urdu

Y: family member is better

M: yeah, she said family member is better

SP: why?

M and Y: Urdu

M: yeah other people, she doesn't want other people know, like the Asian community majority of them, they start soaking this kind of like thing up like, it's different and they start like soaking up each other people's life-stories and stuff and she doesn't like it, she'd just rather be around family members

SP: so do you think there's something about the confidentiality

M: yeah

SP: of the information, for the interpreter?

M: mainly privacy thing yeah

SP: ok, is it somebody that you know? Do you recognise them or..

M: no, some you know some you don't, some be local you know like, yeah some local like, ***'s sister.

Y: Urdu

M: people start talking and like..

In this extract the idea of using formal interpreters is progressed to include confidentiality, which was also raised in the first case study. Despite the differences between Rehana and Yasmin's experiences, both explicitly identify concerns about confidentiality and associate these with the community.

The focus in this section of text moves away from Yasmin's concern for her son's position to confirm that if offered the choice she would prefer the support of a family member, echoing her son's understanding that this choice offers more than just the practical aspects of facilitating communication. Yasmin chooses to use English language for the first time in the interview to express this. Prior to the interview Yasmin and I spent several minutes communicating in English whilst waiting for Mohammed to arrive, however during the interview she chooses to communicate via her son for all but a few statements. This is another example of Yasmin enabling her son to perform his preferred identity, as her advocate and protector. Mohammed repeats his mother's exact English words himself, still maintaining his position as important in the interaction, as if adding credibility to her statement.

The statement is followed by an exchange in Urdu, then a section of text explaining Yasmin's concerns via Mohammed, who attempts to explain 'the community' to me, an outsider who he presumes not to possess this knowledge. In this explanation Mohammed uses the words 'it's different' to describe the 'Asian community'. By identifying the community by the ethnicity of its members we can see that my whiteness defines my position as an outsider according to Yasmin's son, the 'difference' he attempts to explain is between the 'Asian community' and the 'white community'. Mohammed also refers to the

community members as 'they' on two occasions within this short section of talk, thus positioning himself as separate from 'them', to include himself would require the use of 'we'. This may be due to the negative focus of the exchange, highlighting problems with confidentiality within the community, however this could also be considered as Mohammed positioning himself as unrestricted by the boundaries of 'the community' which we see in the final extract transcend geographical locations.

Mohammed repeats the description of members of the Asian community as 'soaking up' 'this...kind of thing' twice, indicating the way that information is shared about people within the community. Although this is described as 'different' to the white community by Mohammed, there is gossip between families of all ethnic backgrounds, with historic white stereotypes of 'fishwives' exchanging tales. It is the 'kind of thing' being shared about Yasmin that she does not like; her 'life-story'. In the previous extract we see Yasmin divert to the issue of interpreters rather than discuss her mental health, and again in extract 4 we will see both her and Mohammed favour a medical approach to her mental health over counselling or talking therapy, a perspective identified in the literature review (Lawrence et al. 2006). This indicates Yasmin's unease lies less with the sharing of information, and more with the information that is being shared, relating to the stigma surrounding mental health issues and her fear that her attendance at a counselling session would be shared within the community. Although it is not clear whose words are prioritised by Mohammed in interpreting this section, it is what is absent from the discussion, by Yasmin here, and throughout the interview, that indicates a discomfort with discussing mental health that is different to her physical health.

The final exchange in this extract returns to the integrity of formal interpreters, with Mohammed clarifying that although some interpreters are known to him and Yasmin, giving an example, others are not. Mohammed doesn't confer with his mother before disclosing this information, indicating that he is expanding on her initial point from his own experience. The use of a common phrase in English language; 'some you do, some you don't' supports this assumption, and the use of 'you' rather than 'we' or 'I' in this scenario indicates that Mohammed is generalising his statement. The generalisation here appears to be Mohammed speaking for others in the same circumstances, specifically other families in the 'Asian community'. Despite distancing himself from 'them' earlier in the interview,

Mohammed now positions himself as a spokesperson for the Asian community, presenting the challenge of confidentiality as a shared one.

By the end of this extract, Yasmin is presented as a woman who is balancing her own anxieties about medical treatment, stemming from poor experiences of care, which although not internalised to challenge her identity as part of an oppressed group, still impact on her desire to access support. This is balanced with contributing to her son's impression management and managing her own reputation within the community, which she believes would be detrimentally affected by the stigma of needing to access mental health services.

6.3.4 Extract 4

M: there was one counselling session she used to go to and his name as Dr Khan, and he was a professional psychiatrist from the XX Health Centre, he was good, he was very good...

SP: what made him better, do you think?

Y and M: Urdu

M: he was good he was like, you know like er... brainstorming like using obstacles; 'what would you do at this certain time and that' he wasn't going into family details like 'what would you do this for, what happened in your family like' you know, that's like, *personal*, he was actually working the brain, cause obviously he's a professional psychiatrist and they know what they're doing, and I was there you know as well and then you're seeing inside and the counselling, he was very, very good. He was very good.... And er, the other one's like XX Centre* they've helped a lot like you know like they've put extra rail in, and a step up at the back, you know support stuff in the shower and you know things like this and the toilet they've put railings on the side, grab rails, they're ok innit?

**multi-professional public access building in the centre of the town*

In this extract, we again see Yasmin and Mohammed's attention to detail, identifying both the name of the psychiatrist and the surgery to begin the narrative. Although the exchanges between the pair are spoken in Urdu, several words are recognisable or are spoken in English, including names of people and places, indicating that the identification of key facts such as name and location are recalled through discussion. This contributes to

my understanding of the final talk presented to me in English as a refined and negotiated co-construction, rather than an exact interpretation of Yasmin's words.

Here we are presented with a narrative of what Yasmin and Mohammed understand to be 'good care practice', which is contrasted with the two previous experiences of care; the 'rogue doctor' and the 'too personal' group counselling, which included the added risk of damaging Yasmin's reputation amongst her peers.

It is clear from the repetition of 'he was good, he was *very* good' at the beginning of the extract, following an exchange in Urdu, that this is to be a positive experience. From examining the structure and performance of the longer narrative, two key ideas emerge; the privileging of a scientific understanding of mental health issues over more person-centred methods, and the reassurance achieved from Mohammed's ability to oversee the session.

The earlier two extracts present Yasmin as unprepared to discuss her mental health, focussing, when asked, on the challenges associated with using interpreters. By exploring these extracts further, we identify that the stigma surrounding mental health services may be influencing Yasmin's decision not to expose this part of her identity. Here we see a return to this reluctance, preferring the psychiatrist's approach as it focusses on practical rather than emotional exchanges, it is not '*personal*' in nature. Mohammed gives examples of the type of questions used by the psychiatrist in comparison to those in the counselling session using direct quotations, reliving the appointment, however in the second extract Mohammed advises that he was not allowed access to the group counselling, it is evident therefore, that Yasmin's contribution is reflected here.

The psychiatrist is given a privileged position in the narrative, both he and his profession are respected by Mohammed; 'obviously he's a professional psychiatrist and they know what they're doing', the use of 'they' generalises this respect to all psychiatrists. In the second half of the extended section of talk, we hear about the XX Centre, a multi-disciplinary resource centre in the town, and another service that Mohammed and Yasmin have valued. Mohammed lists the practical assistance provided by this centre, my knowledge of the local services enables me to identify this as an occupational therapy

service. The recognition of this service as valuable again contributes to the privileging of meeting practical needs over more emotional support.

The second reason Mohammed and Yasmin prefer the psychiatrist is summed up by Mohammed's assertion here;

and I was there you know, as well, and then you're seeing inside, and the counselling

Here we see a return to the presumption that professionals, without being observed, will default to poor care provision, and the idea that familial presence provides more than practical support. Even the psychiatrist, who is respected by the pair, is not regarded without suspicion. Mohammed's ability to remain in the session is supportive to Yasmin, who previously reported being 'afraid' of being alone with professionals, and serves to preserve Mohammed's position as important, compared to the group session, where he was relegated to waiting outside. The combination of these two aspects of the provision; the practical focus and the acceptance of Mohammed's presence, demonstrate by the end of this extract, what a good service looks like to the pair.

6.3.5 Extract 5

M: she's saying, you see if I'm not here, I'm the only one that drops her off you see, I pick her up, drop her off

SP: yes

Y: Urdu

M: yeah, they don't, they don't really *help* my mum to like, they have got like a van that picks the women up but it's only that certain area, that XA* area not the XB* area or the XC* Ward there's only, it's only that certain area

SP: mmm yeah you're a bit of a distance away aren't you

M: yeah they said you have to make your own way, I think there's two, two, three (to mum) Auntie

Y: Urdu

M: XD, yeah there's about four or five women that come from away, out of XA*

Y: Urdu

M: no way, oh they've *stopped* the funding sorry, for the travel expenses, there's nobody now you have to make your own way and go home your own way

**XA – the local 'community' name*

**XB, XC, XD – various neighbouring localities*

This final extract was chosen as it consolidates the idea of good and bad services, and also includes information that helps us to understand Yasmin and the 'community' in relation to space and place. The exchange is predicated with the words 'she's saying', indicating that Yasmin has contributed to the ideas presented in this section, and continues with Mohammed performing his preferred self, identifying his role in transporting his mum to the community centre. Although before the interview started, Yasmin stated that she has three daughters, these are not mentioned throughout the interview, nor are any other family members, Mohammed's word choice here emphasises that supporting his mother is his responsibility, 'I'm the only one', the inference being that none of Yasmin's other children play a role. This statement enables Mohammed to position himself as having the most important role in the family.

Following another exchange in Urdu, Mohammed states that the Community Centre 'don't really *help* my mum', the emphasis on the word *help* indicates that the centre isn't regarded as a support service by the pair. Throughout the interviews, and during my year of attending the weekly luncheon club, the women who attended all discussed the benefits they felt the centre brought them, with several recognising the hard job that the organisers had in ensuring the club received funding despite the current political climate and the impact of austerity. Using my understanding of the context, I believe that the reference to not '*helping*' here does not indicate that Yasmin does not benefit from the clubs and events that the centre hosts, but does help us to understand that in contrast to the privilege attributed to practical and medical support services, the community centre and the social and emotional peer support provided by the luncheon club is not valued in the same way.

The final section of the extract focuses on the travel arrangements for the luncheon club; the Community Centre had provided a mini-bus to transport some of the women to and from the club, however this had at the time of interview, recently been withdrawn due to council austerity measures. Because of the area Yasmin lives in, she was not able to access

this transport, and as we saw earlier Mohammed drove his mother to and from the group. In discussing this we can see Yasmin located within the 'community'; despite not living in the XA* area, referred to by Mohammed as 'that certain area', a statement repeated twice in the short section of speech, Yasmin remains part of the 'Asian community' described in extract 3. Between the pair they identify three different geographical areas of the town, separated by their inclusion or exclusion from the now retracted transport service, but all these locations are connected by their inclusion in the 'Asian community'. This indicates that the meaning of 'community' in this instance transcends the geographical location of its members, providing a contrast to the first case study, where Rehana and Ali saw the community as relating to the geographical location over the ethnicity of the workers operating within it. This lack of shared understanding of community challenges the popular stereotype of 'Asian communities' as possessing a fixed identity.

The extracts above describe the poor treatment Yasmin has experienced, however these are not racialised by either her or Mohammed. Despite Yasmin's reluctance to return to a health professional without her son as chaperone, she does not appear to have internalised these negative experiences, instead, her strong informal support system promotes a positive, if gendered, self-identity in the face of poor treatment.

6.4 Farah

Farah's interview was arranged differently than the other participants as I asked her directly if she would be prepared to be interviewed due to her role at the luncheon club. Farah can speak fluent English and is a foster carer for the local authority. She has a young adopted daughter and a teenage foster daughter; the latter occasionally attends the luncheon club with her. As one of the only women to communicate confidently in English, and with some knowledge of local authority systems she is seen as the unofficial leader of the group; it was Farah who originally helped me to explain my research project to the women and she has often helped me by interpreting when women have wanted to ask questions of me during the group.

On the day of Farah's interview there was some confusion as we had both documented different times for the interview (I was wrong), and Farah called me to ask whether I had forgotten our arrangement. This was some indication of the different power dynamic between us as none of the other women had contacted me themselves.

Farah lives in a large detached dormer-bungalow in a 'nice' part of the town, some distance from the community centre. She lives with her husband, young adopted daughter and teenage foster daughter, one of her three sons lives next door with his wife and children. Two of the sons are solicitors and one is an accountant, of her three daughters in law, two also work, one is a solicitor and one a teacher. Outside of the house there are numerous high-end cars, a topic Farah covers in her interview. Although a similar age to the other women members of the luncheon club, Farah presents as much younger, she is still active, able to drive and describes her keen involvement in her daughter's school and nursery. When asked about health problems Farah described only that she had noticed herself slowing down when entertaining her daughter, and her desire to lose some weight, compared to the more serious health issues the other women had discussed.

As I had a closer relationship with Farah than the other women, due to her language support with the research project, the interview was much more conversational. She covers topics such as her relationship with their fostering and adoption social worker, a recent trip to the Trafford centre, the family's previous business ownership and her links to the community centre. Despite being clearly more affluent than the other women, and with other connections, Farah still attends the community centre and sees this link to her

peers as important; she describes how she was in a bed next to one of the other women at the local hospital following the birth of one of her sons, stating that their friendship stemmed from this meeting.

Farah didn't require an interpreter and the interview lasted considerably longer than the others, with Farah relaying long and complex narratives about many aspects of her life. Because of the extended nature of the narratives, an analysis of each, including presentation of the transcript is beyond the scope of this thesis, therefore the way the narratives are presented here has been modified. Important narratives were identified using features required by dialogic performance analysis, from these, the extracts presented below were chosen by relevance to the objectives of the study.

The chosen extracts have been edited more closely than the previous two case studies, with text removed where this did not alter the focus of the narrative. My responses have also been edited and are removed when indicated, with the same emphasis on retaining the focus of the narrative. As dialogic performance analysis concentrates on a combination of performance and structural aspects of the interaction, this editing should not have a significant impact on the overall analysis.

The first collection of extracts are taken from the first exchanges during the interview, they enable us to identify features of Yasmin's performed identity in the narratives she chooses to relay. Our first conversation centres around her belief that the 'other women' at the community centre don't access health and social care services because they are not made aware of them by their GP;

6.4.1 Extract 1

F: nah, if it would happen to me I would go to the counter and say 'excuse me what was that can you give me the leaflet' or 'can you tell me what kind of service I could get' but then if it happens to the other ladies... I do know sometime is you know, from a, you know, Bangladesh people, they don't wanna know, that's the truth, you know they've got sooo many children, three wives, two, two wives and they you know they quite old and they've young wives and if, you go to the doctor, the doctor [gives you] medicine, that's fine, and they have their babies, that's all.

text removed

you know here at lunch club every, quite a few ladies you know, they says yeah if it gets closed, if it doesn't get enough funding we'll be ready to pay you know, pound each, two pound and we can stay, come here and sit together, have a chat and something to eat and they don't mind. But some of them they are very very, tight! Even though it's just a pound or two pound, they don't wanna part with those, no, but the most of it they say 'no, we'll come, and we'll pay as well, happily'

Here we see Farah give clear examples of how she thinks she would respond if she was not offered a service she knew about by her GP. She uses direct speech for this imaginary scenario, and later (not presented) continues using this literary device to state that she would share knowledge with someone else if she thought the service may also help them, positioning herself in this initial exchange as knowledgeable, confident, and kind, a position she returns to throughout. This presentation is reinforced at the community centre, as she is often called upon to support the other women in interpreting when English speaking visitors attend the centre.

Farah differentiates herself from 'the other ladies' solely by her ability to speak the English language, but also here she starts a sentence; 'I do know, sometimes, you know...' rather than complete this phrase, she diverts mid-sentence to a story, thick with stereotypes about Bangladeshi people not wanting to accept support from professionals except for basic primary care. She clearly states; 'they don't wanna know', and continues to mention wives and children, indicating that 'they' here is Bangladeshi men. This narrative of a group making a choice not to engage with services is told here in place of having to say this explicitly in relation to her own heritage, and therefore associating the Pakistani community. Here she attempts to preserve the reputation of the community, avoiding direct reference to this group as disinterested, but instead compromises her own integrity by referring to stereotypical perceptions of the local Bangladeshi population. Farah makes this slip early in our interview, and although using this technique as a way of expressing her understanding that some people may not know about services because of their own lack of interest, rather than failure on behalf of the services, she shows her own prejudices here. Farah reveals this side of herself apparently without recognition, as it contradicts her performance in other narratives.

Farah uses the term 'that's the truth' to verify her position, as if attempting to remove any negative implications from the prejudicial narrative that follows. Rather than establishing the narrative as her opinion, this term serves to present her as knowledgeable, as she 'knows' the truth, and is informing me, the outsider. Throughout the interview Farah uses phrases, including using my name 'you know Sarah' as a way to demonstrate that she is confiding in me, or sharing a 'truth' previously unknown to me. This shows that the presentation is performed for me as an individual with some shared understandings, as our relationship was closer than that held with the other participants, but also positions Farah in a position of power, as the more knowledgeable insider.

The second half of the above extract focusses on the recent concerns that the luncheon club may lose funding. Farah raises that many of the women are prepared to pay, again preserving the reputation of the community, presenting them as generous and invested in the club. Interestingly she then makes another slip, in the reference to some of the women as 'very, very tight'. Immediately after this she recovers, reassuring me that 'most of it (the women)' would be happy to contribute towards maintaining the service. In this instance Farah's reference to the women as 'tight', or careful with their finances, is indicative of her different socio-economic background, and her lack of awareness of the impact that poverty may be having on the women she refers to. The flippant; 'it's just a pound or two pounds' shows her as oblivious to financial situation of the other women, such as Rehana, who struggled to find the transport costs to and from hospital appointments. Here we can see my failure to challenge these slips, or explore them further, as enabling Farah to maintain the performance of her preferred identity and preserving our relationship as Farah has offered me access to 'backstage' information on the basis of our personal relationship, relating to me not as an insider but as trusted outsider.

By the end of these extracts we can see Farah position herself as part of the Pakistani community, and keen to present its members well, avoiding damaging their reputation by veiling negativity in a narrative about a different ethnic group. She separates herself explicitly only by her ability to speak English at this point in the interview and positions herself as knowledgeable about the other women's lives despite evidence to the contrary. Farah presents herself as confident to ask for information and prepared to advocate for others should the opportunity arise. In relation to me as the researcher, Farah uses terms

that indicate she views me as an equal, and confides in me more as my individual self, rather than performing for the profession I represent. The two slips Farah makes suggest that despite her attempt to present her preferred self, she holds prejudices about other communities, and is unaware of the impact of poverty on the lives of members of her own community.

6.4.2 Extract 2

This extract follows a narrative where Farah describes the fire service visiting the community centre and encouraging the members to contact them via phone to arrange a free fire alarm fitting. Many of the group take up this offer but are unable to contact the service and receive no response to messages they leave on the voicemail.

Farah moves from this example of poor practice, which is not explicitly racialised, to describe an incident of racial abuse she encountered in the local town, this encounter is referred to again in three separate sections of the interview. One of these further references is included in extract 4, where Farah moves smoothly from describing racialised health care back to the incident, indicating that for her there is a relationship between the two events.

F: in B and M here, I went, and er because, so, I went in, came back and there was an old couple standing, they had a car, standing next to the car, they said *loud voice* 'oh look at her, that Paki's driving a BM' honestly, its *laughs* honestly, I came home and I told my husband and he said 'you should have, what you should have done is taken your phone out and taken the picture of the car and the person and just complain' you know so you know it's racial abuse.

**text removed – discussion of contacting police*

F: They, they didn't know who the car was that they were parking behind, you know they were assuming its some white person going to come along sit in their car, so when I came and put my stuff in, they were standing both you know, outside next to the doors, and er, I just turned my car alarm off and as soon as I went he said 'look at that Paki driving a BM, yeah, here and she's driving a BM' I got so you know I said, 'forget it, no point talking to you or saying'

At the beginning of this extract we see a false start from Farah, where she struggles to find a comfortable way to ease into telling the story, alluding to the fact that this is a difficult

narrative for her to disclose. Once she does start she provides a very matter of fact explanation. She describes the couple in the story as 'old', a point she refers to in the next extract, as this holds some importance for her. Farah gives a speaking role to the couple (a technique Riessman suggests is an indication of significance) repeating their line twice in the extract, the first time referring to 'they said', not indicating which of the couple spoke, perhaps not a point of importance for her, but clarifying with 'he said' in the second utterance that it was the male. In later references to this event Farah refers to 'the couple' rather than 'he', with her generalising the racist statement made by the man onto his partner's beliefs also, seeing them as complicit in their racism.

Farah not only recites the direct speech from the incident; 'oh look at her, that Paki's driving a BM', but also raises her voice and uses a different tone, fully re-enacting the event, presenting this as a key point. Her emotional response to this event here is short, and incomplete, repeating 'honestly', whilst laughing, unable to think of words to describe the emotion attached to the event, and laughing in disbelief. Farah then moves on quickly, not dwelling here on her own emotional response, although this is returned to in the later extract. She follows with another speaking role, this time assigned to her husband's response, encouraging her to report the incident, advice that she doesn't take. In lines removed from the text Farah refers to this as 'pointless' and, referring to another narrative not presented in this case study, 'even the police are racists'. Here we see Farah again acting in opposition to the preferred self she initially presented, as confident and prepared to challenge when required, brushing off the incident. She is instead positioned as powerless in the face of the racist couple, with her final statement in this extract, a speaking role given to herself, confirming this 'forget it, no point talking to you'. Farah states that she 'said' these words, however from my knowledge of Farah, and from a combination of additional statements in other parts of the text I believe she thought this rather than speaking out loud. Other extracts also see Farah give her thoughts speaking roles, predicated with 'said', rather than 'thought', therefore this is in keeping with her language use throughout. In this statement Farah indicates that the reason she doesn't respond to the couple is because it is pointless to do so, however later in the interview Farah tells me a story about a dentist friend, who tours Mosques encouraging young Muslims to speak out against racism, a sentiment she agrees with. This contradiction in what Farah believes,

and her assertion here that it is 'pointless' to challenge racism indicates that Farah may not be able to admit her fear of challenging the couple, or her struggle to understand their racism, a theme explored further in extract three.

Farah explains the event to me, informing me of the couple's expectations, and aware that her presence, as a Pakistani woman, had challenged their assumptions, leading them to speak out, she does this using repetition of the term 'you know', denoting her presumption of our shared understanding; speaking outside of a professional encounter to me as an individual. In her explanation Farah refers to 'some white person', again demonstrating that to her, gender did not play a role in the couple's assumption.

In this extract we again see Farah act outside of the usual performed identity created for herself in our initial interactions. In the face of direct racism, Farah finds herself unable to speak out, justifying this by referencing racist police and referring to any attempt to influence the couple as pointless. In contrast to Rehana and Yasmin, Farah has significant capital, she owns an expensive car, is educated and can communicate in English, however here we see that these privileges do not enable her to avoid racist encounters, in fact, her ability to travel independently has increased her risk of exposure to racist experiences. This extract also demonstrates that despite Farah's initial presentation of herself as a confident and assertive individual, that her socio-economic privileges do not give her the confidence to challenge racist incidents when directly confronted with them.

6.4.3 Extract 3

In this section of talk Farah discusses what she sees as the difference between white and Asian people's responses to poor service provision. She then returns to the incident of racial abuse described in extract two, to give an extended account of the encounter. The emphasis on this event throughout the interview indicates the extent to which it has affected Farah and analysis of this extract gives us some understanding of the significance of this event.

F: the white people, if they don't do what they, do what the people say, the patients says, and they, if doctor doesn't listen, she says 'oh no I'm not happy with your service I'll go somewhere else' or 'I'll tell someone else', so they are very good in that point, they do look after you, they do, even our Asian people, very good to white peoples, and they're very good with the, yeah oh yeah, 'you don't need that

medicine you go and you'll be fine' and it's, it's these kind of, and with the white people it's really, really good, I mean if they're good the surgery's good, everything's good and then you have no problem. You know like it happens to me even though I'm like I'm not with a hijab on, I do wear scarf, but you can see everything but you know, the old couple were so racist, I mean he couldn't take it that I came and I sat in the BM, and he couldn't take it

SP: you should be able to do what you want

F: eh but you know my husband's working, my children's working, I'm working away you know like a foster carer, so what can we do, we don't smoke we don't drink, you know I don't, we don't, so we don't spend on the cigarettes we don't spend on the drink and yes, I do like, we do like nice cars, who doesn't though, if you've savings, money from this side and you're saving it to buy a nice car, of course you buy a nice car, but somebody, third person doesn't have a right saying 'look at that Paki woman she's driving a BMW, oh look at her' I mean he was *so jealous* you know on the face, the eyes, I couldn't believe it you know, that nice, you know mature couple could say those words

**text removed*

F: I think he worked for his life to get a nice car and er why shouldn't nobody have a right to say anything but I was so shocked, it wasn't just a young couple who, you know they could say that but he was *nice, old mature couple* that couldn't take well, I don't know he had a really bad experience with an Asian or I don't know **laughs**

In the first section of this extract Farah is outlining her understanding of the difference between Asian and white people's responses. She describes 'the white people' as a generic group, with their whiteness as their only defining characteristic, referring also to the equally generic 'the people' and 'the patient', indicating the importance of ethnicity over other characteristics in this example. Farah then moves on to illustrate her point by giving the white people a collective speaking role, using two fictitious choices of response to poor service, both relaying a course of action. Using the pronoun 'she' to ascribe a gender to this collective white response, Farah describes the fictitious white patient actively challenging poor service, generating fear of being reported in the service provider (the doctor in this example), and ensuring that their treatment remains of high quality.

Here Farah is describing white people as using their ethnic privilege to ensure they receive their expected standard of care, acknowledging that whiteness affords patients a higher position. She reinforces this idea by explaining that 'even our Asian people' are 'very good to white peoples'. Making it clear that not just white doctors privilege the experience of

white patients, but that Asian doctors also prioritise their satisfaction. Here Farah refers to 'our' Asian people, indicating her identification with her ethnic group, positioning herself, and them as afforded less privilege than her white counterparts. Farah however, does not appear concerned by this apparent inequality, rather she presents this as factual information, using terms 'are' and 'is' to denote certainty about her opinion. In her final few sentences of this section, she describes the impact of white patients and their tendency to complain as benefiting everyone, describing the service as 'really, really good'. Farah returns to this idea of 'white people's surgeries' in a later extract.

Here we see some commonality with the earlier two case studies in terms of subjects raised, but much difference in the way these themes are presented. Primarily where Rehana saw the poor service she received as racially motivated but individualised, resulting in this being internalised, damaging to her identity and affecting the way she responded in consequent interactions, Farah also sees the racialised treatment, but understands this more collectively. Rather than referring to herself, she refers to 'our Asians' and 'white people' more generally, and, although acknowledging that the doctors prioritise white people's satisfaction, she does not internalise the negative implications of this for herself as an Asian woman.

Additionally, Farah explains the rationale for the high standards of practice in 'white peoples' surgeries as resulting from their collective willingness to complain if dissatisfied. This resonates with both earlier case studies, as the implication is that doctors are only performing well due to fear of reprisal, rather than because of professional ethics or a strong value base. This is a reoccurring theme, as both Rehana and Yasmin's interviews also uncover the presumption that left unregulated, medical professionals would default to poor practice.

It is important to recognise that Farah's beliefs here are generated from her experiences, which are also an indication of her privilege; later in the interview Farah uses the terms 'white' and 'good' as synonymous in terms of services and indicates that 'white' areas are also synonymous with more affluent areas of the town. By using her understanding here, it is evident that her beliefs are as a result of her being in a position to access 'white' services, as she has the economic capital to live in a more affluent area of the town.

Following her discussion of doctor's practices, Farah returns to the racist incident in extract four. Throughout this second section Farah raises several aspects of her identity, as if trying to justify her role in the incident as innocent, but in doing this she also indicates how she understands racism in her locality and in society, and why the combination of both her and the couple's characteristics challenge this understanding. Farah's desire to relinquish herself of responsibility for the incident is in keeping with the performance of her preferred self as a kind and family orientated woman, she is also seeking affirmation from me, as the interviewer, but also as a well-known acquaintance, who she knows from previous discussions will share her view and reassure her that she was not to blame.

The first point Farah makes is in relation to her headscarf; she states that 'it (racism) happens to me, *even though* I'm not with a hijab on'. This statement, with the emphasis on '*even though*', indicates that Farah would have been more likely to understand the racism she was subjected to if she were wearing a hijab, expanding to explain that 'everything' (her face) is visible to others. The inclusion of this section of talk demonstrates Farah's understanding of contemporary culture, the growth of far-right attitudes, particularly mistrust of Muslims in general, and more locally the racial divisions in the town, acknowledging that a woman wearing a hijab may be more likely to experience racism. Here Farah positions herself as a liberal Muslim woman, with a relaxed attitude to her headscarf, reinforced by her appearance during our interview, where she chose not to wear her scarf.

Farah then moves to explore a second identity position; that of a hard-working family, deserving of their privileged socio-economic status as she justifies her family's wealth. Farah refers to each member of her family 'working', alongside identifying that none of them smoke or drink alcohol, thus deeming them entitled to spend their savings on cars. Along with enabling Farah to perform her preferred identity here, as a hard-working family, this section of talk also allows us access to some of Farah's own preconceptions, about attributes that make a person less deserving. Similar to her assertion that she'd be more able to understand the racism if she'd been wearing a hijab, here Farah indicates alcohol and drug use, along with unemployment as 'undeserving' characteristics that might make discrimination more understandable.

Farah is justifiably angry about the incident, she was racially abused in public having done nothing to provoke such an attack. Her anger is evident in her returning to the incident throughout the interview, her repetition of the racist statement using the exact words used, and the tone of her voice, Farah's frustration is heightened by her failure to respond to the abuser, despite describing such an act as 'pointless'. Farah's performance of this information, whilst justifying her own position as undeserving of such an attack, also serves to indicate her own judgments about what may justify discriminatory attitudes, conforming to stereotypical assumptions about addiction and unemployment.

The final section of this extract sees Farah again repeat the statement used during the racist incident, the emphasis on 'jealous' indicating how she understood what happened, with the detailed description and focus on 'the face, the eyes' showing that she had analysed the abuser closely, indicating that she had spent time reflecting on the incident. Here, although Farah identifies facial features specifically, she does not refer directly to the man who made the statement, rather she uses the generic term 'they', again indicating how the couple's attitude is assumed to be represented by the man's statement.

The final lines expose another of Farah's own preconceptions, the statements 'that nice, you know mature couple' and 'he was a nice old mature couple' indicate that the age of the couple is relevant for Farah, with her identifying that she could have expected such a racist and disrespectful attack from a young couple. Her choice of the word 'nice' here is interesting given the racial abuse she encountered, however Farah uses this word to be synonymous with the other descriptors 'mature' and 'old'; 'nice' is what she is telling the audience she would expect from an older couple. Farah describes being 'so shocked' by the racist attitude of such a nice old couple, indicating her own judgments about age in relation to attitude.

The final line of the extract again attempts to justify the abuse, this time not by reasserting her own deserving position, but by externalising the issue, and demonstrating that she understands how prejudice can work. By identifying that this man may have had a 'bad experience' with 'an Asian', Farah indicates that she knows people generalise bad experiences towards those with similar defining characteristics, in this instance she uses her ethnicity.

By the end of this extract Farah openly tells us her opinion about quality of doctor's practice, and revisits the racist attack in more detail, confirming its significance to her, however, analysis of her language use and aspects of her performance tell us much more about how she understands discrimination to work, and what factors she believes influence this. Primarily Farah indicates that hijab wearing, addiction and unemployment are all factors likely to increase risk of discrimination, whereas she sees age and poor past experience as factors that influence whether you are likely to be discriminatory to others. We see more of how Farah understands racism in the next section.

6.4.4 Extract 4

In this extract, which is performed shortly after the section above, Farah describes another racialised incident, referring to this as a common occurrence rather than one she has individually experienced. From analysing Farah's performance, we also see more of her own judgments, which help her to understand racism in a way that protects her own positive identity;

F: but it is, if Sarah honestly the educated people they won't mind these things, but you know the people who are little poor, that's white people, if they see Asian people's got an appointment and he's gone in before you, not before you but you come in late, and you expect to doctor see you straight away or hospital and they start shouting you know, and you know like *in loud voice* 'oh yeah look at this, er, this Paki's gone in, then you before, and we had an appointment before', it makes you nervous you know, you don't you don't know what they're going to do

Farah starts this narrative with the phrase 'Sarah, honestly', a commonly used phrase throughout the interview when Farah wants to tell me something sincere, reinforcing the truth of her words. She moves on to tell me a narrative about poor white people being angry when they perceive Asian patients receiving preferential treatment at the hospital or doctor's surgery, before ending with the impact this has on Asian people.

In the first few lines, we see Farah draw a distinction between the responses of white patients who are 'the educated people' and 'the people who are little poor'. Here Farah seems to divide the white population into educated and poor, an interesting distinction that gives insight into Farah's preconceptions about poverty and education. This

meritocratic understanding of British culture includes an understanding of education as the key to success. This is a reoccurring theme throughout the interview and earlier Farah discusses her own children's success in employment as down to their hard work and commitment to their education, with her and her husband described as having worked hard to achieve their current position. This understanding enables Farah to rationalise and externalise the racist treatment she describes, as resulting from lack of education, rather than internalising the poor treatment as Rehana does in the first case study. This interpretation fits with the shock Farah displayed when faced with the racist couple, who presented with characteristics that did not resonate with Farah's understanding of a 'typical' racist. Farah's understanding of poor people as uneducated also confirms her positioning as privileged, as her socio-economic position affords her the luxury of ignorance in relation to the education of poorer populations. This is the same privilege that allows Farah to understand the women at the luncheon club as 'tight' for not volunteering to pay towards the running cost of the club.

There are limited references to the characteristics of the characters involved in this narrative outside of their education or economic status and ethnic group, indicating that these are the important distinctions in this story. There is also very little mention of gender, with Farah preferring the terms 'you', 'they' and 'we', indicating that this is either a generalised narrative or a summary of many similar experiences, rather than a description of one particular event. Farah does attribute a speaking role to the ungendered poor white racist in the narrative, acting out the speech in historic present, in a louder tone, and attempting to use a local accent to role play the words, again using the racist term 'Paki' in her performance. Farah uses this term frequently when presenting direct text from incidents she has experienced, the ease with which she states this racist slur indicating her familiarity with hearing it used.

The final two lines of this extract end the narrative by establishing the impact of incidents like the one described have on the Asian population. In these two lines Farah uses the term 'you' to represent herself, but also, as this is presented as a generalised incident rather than a specific one, 'you' can be understood as Farah's perspective on how all Asians feel. Here Farah positions herself and those sharing her ethnicity as fearful of the unpredictability in situations such as that described. Despite her privileged socio-economic

status, Farah's ethnicity, in the eyes of the racist, groups her with all the Asian population, and like them, she shares a fear of their response to any perceived preferential treatment.

In this extract we see learn that despite Farah's ability to externalise racist incidents, and see the fault lying with the racist instigator, the short-term outcome remains the same. Farah understands the incident as a poorly educated white racist response to a misunderstanding but is still fearful of the unpredictable outcome. This indicates that her socio-economic privilege, and clear identity boundaries may protect her from internalising the incident, and affecting her self-identity, but do not protect her from falling victim to such incidents. In addition, Farah's perception of the stereotypical 'racist' is influenced by the local context, where there has historically been unrest between the white and Asian community, much of which involved young white males in conflict with Asian males. Farah refers to this unrest in other sections of the interview, validating the importance of this period in influencing her perceptions.

6.4.5 Extract 5

In this extract we see Farah describe her perception of the local primary school, from which her daughter-in-law has recently removed her children, deciding instead to home school Farah's grandchildren. Farah explains why she doesn't like the school and wouldn't send her adopted daughter there. Outside of this extract Farah explains how she enlisted the support of the adoption team social worker to help secure her daughter a place in a better school, in a 'white area', and extends her description of the local school to uncover a racist head teacher and the staff team bullying each other. This additional information enables Farah to position herself as understanding the systems and processes involved in primary school allocation, including the knowledge that as an adopted child, her daughter is allowed access to a school of her choice.

F: you know I don't like the school myself because *pauses* there's more Asian people children, they don't teach them right, I mean they don't get the, you know what they can, my daughter you know where she is she gets you know better, it's better teacher, teacher teaches because you know the white people goes, and asks the teachers what she's done, how she is, how far she's going, you know all these questions they ask the teachers so teacher have to tell them we've been doing this...

**text removed – confirming above*

SP: so do the Asian parents not ask, don't go in to the school and ask?

Y: no not much, not many, because most of them they don't know themselves, like me, because I don't go to school here, I you know I came from Pakistan, I know I've done some GCSE here you know that's all I did, and er, but you know, you can, you know when you go to school if there's a, well Jen where she used to go to nursery and the teacher there...assistant teacher, even they don't know any English, and they're helping the teacher and they're working there, what they going to teach the children, because if they don't know anything how they going to help the children?

Farah's talk transitions smoothly from generalised racist incidents, to racist incidents in health settings, and then on to other professional services, sometimes changing back and forth between different incidents, as if one reminded her of the next. This fluid presentation indicates Farah's understanding of these racialised accounts as interconnected. At the time of interview, Farah was aware of the focus of the research, and as such could be seen as presenting the chosen incidents for my benefit, but the transitions between narratives, and the return to incidents that had most impact on her, indicates her understanding of a commonality between them. In an extract outside of this case analysis Farah discusses an incident of racism a friend experienced at the hands of the police. In this extract she discusses the education system and the local primary provision.

Again, throughout this section of talk, Farah refers to an ungendered 'they', on this occasion in reference to teachers and teaching assistants, with the lack of specifics indicating her belief that the narrative generalises to teaching staff as a collective group. Later comments made specifically about teaching assistants of Asian origin indicates that this collective group is white for Farah. The point made in the first section is that in schools with a higher Asian population, the teaching quality is poorer, because Asian parents are less likely to challenge this than white parents, who are more likely to ask about their children's education and hold the school to account for poor teaching. This is a very similar perspective to that held by Farah about GP practices, where she describes 'white surgeries' as better because white patients would complain about poor quality care and is presented similarly as a concrete fact rather than her belief.

This idea that without being monitored, professionals would default to poor quality care and support is observed across the case studies, and in the other interviews conducted. Similarly to Rehana, Farah understands this default as a racialised act, with white people getting a better service, however she does not internalise this belief to impact her sense of identity. Unlike Rehana she does not see this as a personal attack on her as an individual, rather as a statement of fact. Contrasting with Rehana's position, Farah has the privilege and cultural capital associated with speaking English, and, through her interaction with local authority services, she has the knowledge to remove herself from the cycle of poor treatment. Farah's socio-economic privilege enables her to live in a 'white area' and access a 'good surgery' (explored further in the next extract), and although she still experiences racism in her daily life and feels unable to challenge this either systemically or individually, she understands how to lessen the impact on her life. In this case by enlisting the help available to ensure her daughter is not affected by the poorer quality provision she believes is generally offered to Asian children.

Farah presents her understanding of the interaction between a white parent and teachers, using 'she' to describe the imaginary pupil. Given that Farah usually uses non-gendered references, we can presume that in this imaginary interaction, she is considering her own daughter, and the positive impact that the white parents' interest in their children's education has on her, due to her enrolment at the same school. This understanding contrasts with those represented in the other two case studies and can be explained by Farah's socio-economic privilege; because she is able to access 'white' facilities, which she sees as synonymous with good facilities, she is privileged with the same high-quality service that they have access to. This can be contrasted with Rehana, who, without socio-economic privilege, or the ability to communicate in English, is unable to refuse or challenge the poor services she has access to, and instead internalises the poor treatment as individualised, and consequently impacting on her identity.

In the second section of the extract Farah responds to my question about Asian parents querying their children's education. She replies by using herself as an example; 'like me', describing Asian parents as lacking experience of the English education system, and having low academic achievements, again using her 'some GCSE' as an example. Farah presents herself as similar to other Asian parents, not understanding the school system, or able to

challenge poor service, citing the poor language skills of some teaching assistants in schools with high Asian populations as an example of what she perceives to be poor service. This is an interesting and conflicting presentation, as Farah moves to position herself as modest in her undertaking of GCSEs, an achievement none of the other participants had completed. She presents herself, alongside the other Asian parents, as inexperienced in dealing with the academic system, a position in conflict with the narrative presented prior to the extract, where Farah describes with detail how she and the social worker negotiated a place at another school, clearly demonstrating her understanding the regulation around looked after and adopted children.

In presenting herself as similar to the other Asian parents, Farah also fails to recognise her relatively unique position, as a woman over 60 years old, with grandchildren older than her adopted daughter, Farah generalises assumptions about the lack of education amongst her own age group to the parents of primary school aged children, a generalisation that is unlikely to bare any truth. My contextual knowledge of average family composition in Pakistani families would indicate that most parents of primary school aged children would be a generation younger than Farah, more akin to her children's age. As explored in an earlier extract, Farah's children are all highly educated and work in professions requiring post-graduate qualifications. From the last extract, we know that Farah links education with higher socio-economic status and lack of education with being 'poor', we can therefore infer that Farah is describing poorer families when she is discussing the inability of primary school children's parents to challenge poor education provision.

In this section of the text we see Farah attempt to associate her own experiences to those of other Asian parents, however in doing so we see her fail to recognise her unique and privileged position in relation to those she describes. In the final few lines, Farah uses an example from her daughter's nursery, where she states that the teaching assistant's standard of spoken English was inadequate. Farah does not indicate what the assistant's first languages were but given the context of Asian parenting, we can infer that these individuals were of Asian origin (to use Farah's terms). The use of this example enables Farah to position herself as concerned about her daughter's education, which fits with her preferred identity as a good, family orientated mother, but also contradicts the stereotype of Asian parents she tries to assimilate to earlier in the extract, as disengaged from their

children's schooling. Instead this position separates Farah from this group and relates her back to aspects of her preferred identity; encouraging her children to succeed and focussing on education in order to do so.

By the end of this extract, we see Farah confirming her belief that 'white' services are synonymous with 'good' services, and that she experiences this as positive due to her own privilege, and ability to access the benefits of such 'good' services. We also see Farah infer this judgment onto schools, and explain, from her experience, why this is the case. Here Farah fails to identify some discontinuities in her presentation of self, and, while attempting to position herself alongside other Asian parents, she instead presents some of her own judgements about the low education level of this group. These judgments reflect Farah's understanding of this demographic, but are not representative of the group, and also indicate a stereotypical understanding of the people she is attempting to position herself with.

Farah's inconsistent presentation here, and across the other extracts is indicative of the complex and dialectic nature of identity. If we understand identity as fluid and interdependent on the context, we can see that in discussing different events across the narratives, Farah's presentation of self, and her positioning alters. When compressing these separate narratives in analysis such as this, the changes in preferred self, become more apparent.

6.5 Conclusion

Throughout Farah's interview we see her perform a variety of aspects of her identity; we see her connection to her family and desire to be accepted as a good parent and wife, we also see her describe her readiness to help others to be provided with the professional support they require, although this aspect of her identity is not always born out in Farah's actions. Despite this positive identity positioning we also see Farah as multi-dimensional, with prejudices of her own, in her opinion of professionals, young people and those of lower socio-economic status. Farah positions herself as humble and modest, not able to openly display her wealth or pride in her parenting skills, but analysis of her language and performance uncover these aspects of her identity.

Farah's economic capital and the accompanying cultural capital of English language skills enable her to experience a much more diverse space and place, however these privileges do not protect her from racialised treatment. Farah does experience racism from the general public, and is affected by this, as we see her retell the narrative of the racist couple in the car park throughout the interview, but she is able to manage this without internalising the negativity, and counter it with what she sees as the positive outcomes of 'white people's services' on her own life and that of her family. Farah's language skills, along with the confidence of having a higher socio-economic status, allows her to position herself as knowledgeable in several different areas throughout the interview.

The use of case studies in this chapter demonstrates how dialogic performance analysis uses analysis of the text and linguistic devices in combination with the researcher's contextual knowledge to build an understanding of an individual's identity and attribute meaning to their narratives. In this thesis the focus is on health and social care services, therefore the narratives presented emphasise this. It is likely, as Riessman (2008) found, that the participants if consulted, would not necessarily place as much importance on this area of their lives however, through focussing analysis on one central theme, we are able to draw parallels between participants. The next chapter presents these themes.

7. Thematic Analysis

7.1 Introduction

The previous chapter demonstrated how dialogic performance analysis of individual interviews can be used to give meaning to participant's narratives. This close attention to the stories of the women interviewed can also enable an understanding of an individual's identity development and how this is performed in the various narrative accounts within an interview situation.

Following this process, thematic analysis was conducted to allow us to consider whether there are consistencies in the experiences of the participants in relation to their interactions with health and social care, despite their diversity. The analysis used the extracts of narrative identified during the dialogic performance analysis as the data set and followed Braun and Clarke's (2006) six phases of thematic analysis, as summarised in chapter five. Appendix four and five include diagrams of the thematic maps developed through this process.

The analysis developed four interconnected themes, each containing several subthemes, all listed below. Braun and Clarke (2006) encourage researchers to acknowledge the subjective nature of thematic analysis, therefore it is important to restate that the themes were developed through analysis rather than emerging from the transcripts;

1. Racism
 - Health and social care settings
 - Generalisability of racism
 - Inequality
 - Complaints
 - White = good
 - Asian professionals and White recipients
2. Expectation of poor care
 - Letting them get away with it

- Take backup
- Low expectations
- 3. Space and place
 - Safe and unsafe
 - Challenges to the safe space
 - Complexity
 - confidentiality
- 4. Intersectionality
 - English language skills
 - Managing abuse
 - Using privilege
 - Complex in-group relationships
 - Reluctance to complain
 - Unwillingness to pay for the luncheon club
 - Refusal to travel to services

Each of the first three themes are explored below utilising shorter extracts from the text and reference to the theories outlined in chapter four to analyse their relevance to the research questions. Each theme is concluded with a short 'implications' section which outlines its relevance. Chapter nine expands on the implications of the analysis for both the participants and current practice.

7.2 Racism

7.2.1 Generalisability of Racism

Several of the participants described experiencing racism. Incidents ranged from explicit, racially motivated verbal abuse, through explicit and implicit organisational racism to everyday microaggressions. Overall, most participants and their interpreters (where present) identified and named this as racism in their own way during the interviews and these experiences in some way explain the second cross-cutting theme; expectations of poor care.

In the previous chapter we met Farah, whose higher socio-economic status afforded her the privilege of independent transport. However, although a privilege itself, this independence also meant that Farah was exposed to more varied racial abuse. Farah's clear descriptions of two racist incidents in public spaces and her attitude to state institutions such as education and policing, alongside health services demonstrate the way that racism can become generalised across the spectrum of situations.

Generalisation happens in two ways within the transcripts; *between incidents* and *within incidents*. Generalisation *between incidents* is demonstrated when an occurrence in one interaction shapes the individual's expectations of future interactions. In Farah's case we see this in her expectations of professionals to behave in a racialised way, an expectation that has developed from past interactions and shaped future expectations, this expectation then shapes Farah's sensitivity to behaviour that fits with this generalised expectation. Returning to the theories of chapter four can help understand these generalisations; we can assume that Farah believes the primary identifier of ethnicity has been applied to her by those she interacts with (Jenkins 2014), and that there are stereotypes associated with this identifier, referred to as 'stigma' by Goffman (1968), or 'stereotypes' derived from reductionist interpretations of representational systems by Hall (2013). She deduces that this stereotype and the negative implications it carries will then be applied to her by professionals generally. In making this assumption, Farah is also conforming to these theories, as she is using identifiers and stereotypes of professionals to make a presumption about their behaviour.

Generalisations *within interactions* are made explicit by use of language. Here the use of generalised pronouns are applied to specific scenarios, indicating that the behaviours displayed by an individual have been generalised to those seen to be in the same category. An example of this is Rehana's use of 'they' to describe one individual's behaviour; use of 'they are racist', in reference to one incident with a nurse who displayed discriminatory behaviour indicates that this racialised treatment is generalised to nurses more broadly.

In line with Jenkins' (2014) theory of social identity, Farah's location in a local and national context has shaped her construction of 'a racist'. We see this in the shock she expresses when faced with an older, assumed to be middle class, white couple racially abusing her in

a superstore carpark. As described in the previous chapter, Farah returns to this incident several times during the interview and finds it incredulous that a couple with such high status would hold such views. For Farah, her socio-economic and educational privilege allow her to 'other' racists as young, stupid and poor; we see this in her reference to another car park incident, when she is abused by an overweight man from a poor area of the town and refers to him as 'those kind of peoples... big in the weight and the size of the mouth'. Again, when racially abused in a hospital waiting room; 'the educated people they won't mind... but you know the people who are little poor... they start shouting, you know'. Farah's repeated use of 'you know' here and throughout her interview indicates her belief that the stereotype forms part of a shared understanding with me, the interviewer, and is part of a generalised and accepted stereotype or representational system developed to identify 'racists'.

We can see how Farah's individualised experiences, and privilege have contributed to her perception of racists, but this has also been informed by the local context. She, and the other participants live in a town with a relatively recent history of racial violence; there was largescale unrest in the town in the early 2000s, resulting in prolonged street fighting between white and Asian mostly younger men over several days. Farah is the only participant to speak explicitly about this unrest, referred to locally and nationally by the media at the time as 'riots'. In her short narrative about this period, she includes a generalisation to other racially motivated unrest occurring around Britain at the time;

when they had the riot in Leeds they were white boys that started and they got off and they caught the Asian people and put them in the jail

Here we can see that Farah's beliefs about discriminatory policing are generalised to her town from another area of the country and are then used to inform her construction of racists, as young white males. This deconstruction of Farah's construction of a racist helps us to understand her racialised experiences, but she is not alone in generalising racist and discriminatory behaviour.

7.2.2 Health and Social Care Settings

Farah's educational privilege, and ability to speak English enabled her to describe her life and experiences in great detail, whereas the other participants (bar one) were dependent on a family member to interpret their responses and were therefore more likely to remain focussed on the questions asked, rather than expanding without prompt. Several participants did however present narratives that relate to discriminatory behaviour by health and social care staff. Because of the limited involvement of participants with social care, most of these discussions focussed on the local GP surgery or hospital visits, and generalisations were made both between and within incidents in these settings.

In the previous chapter we met Rehana, who described experiencing the most racism of all of the participants, these incidents were mostly experienced in interaction with health and social care services. Rehana's low income and lack of English language skills, along with her physical and mental health issues mean that she has limited experience of interaction with people outside of her self-defined 'community'. This is explored further in the 'space and place' theme but it is important to note here that this does mean the racism she experiences constitutes a higher proportion of her non-community-based interaction than the other participants describe.

Rehana shares three separate narratives to illustrate the racist treatment she experiences when visiting a hospital. In each she identifies her ethnicity as the main reason for what she perceives to be discriminatory treatment;

Incident 1: Rehana is referred to as illiterate by the Pakistani interpreter, who states 'they're illiterate people' in relation to Rehana's place of origin in a rural Pakistani village when she is unable to understand the interpreter's translation of the consultant's information about a complex medical issue.

Incident 2: The consultant and Pakistani interpreter laugh together at Rehana's failure to understand interpreted information on another occasion; 'she says she speaks Urdu but she doesn't understand *me*' says the interpreter, emphasising Rehana's understanding rather than her language skills as the issue.

Incident 3: During an in-patient stay following an operation, Rehana perceives herself to be ignored by the nursing staff and describes them failing to offer her

support with personal care activities until the consultant appears on the ward, at which point her needs are attended to more closely. During this narrative Rehana also identifies discriminatory treatment in terms of the number of visitors she is allowed compared to white patients.

Each of these narratives, and the impact of them on Rehana's identity are described in more detail in the previous chapter, however here we focus on the generalisations made by Rehana between these individual experiences, and the hospital staff more generally.

The first two incidents Rehana discusses begin with a general description of poor care, for example interpreters cancelling at the last minute and the implications of this that are specific to her personally. Throughout these narrative descriptions, Rehana, through her interpreter, describes the hospital staff as 'they', independent of their professional background. This is occasionally clarified as 'the doctor' or 'the interpreter', when more than one professional is present in the performance, but most often 'they' is used, indicating that Rehana has used her specific experience to inform a general construction of said professional group;

she...they could turn up, make sure they turn up, if not sack em ha ha!

In this sentence, the interpreter self-corrects, as Rehana has just described an occasion when she was sent home from an appointment without seeing the consultant because the interpreter had failed to attend. We can see by the choice of pronoun that she has taken this specific incident and generalised this to all interpreters, as if this is a common occurrence for her.

Another linguistic device used to indicate generalisation of an individual event is the use of plurals; following the second incident, Rehana describes how ridiculing by hospital staff made her feel upset and becomes tearful. She states that 'the doctors even make her feel uncomfortable'. Here the plural 'doctors' indicates that she is referring no longer to the specific incident described, but a general response from doctors. The use of present tense for this also emphasises the generalised nature of the comment 'make her feel'; doctors

continue to make her feel uncomfortable in situations like this, rather than on this one occasion, one doctor *did* make her feel this way.

Rehana's final incident is a contrast to the first two, although carries the same message. Here the same linguistic devices are used but appear in reverse. As Rehana describes the events of her hospital stay, the pronoun 'they' is frequently used to refer to the nurses and the poor care they have provided, indicating Rehana's perception of the staff as all holding the same racist views and behaving in the same discriminatory manner. At the end of this narrative, after using 'they' to describe the nursing staff's discriminatory approach to hospital visitor allowance, she refers to a specific individual; 'maybe because *she's* racist'. Here Rehana indicates that she is referring to one specific nurse and her racist beliefs. Again, as in the second incident, the use of present tense '*she's* racist'; she is, rather than she was, indicating that this label remains attached to the nurse, and therefore potentially labelling all nurses, as part of their identity, rather than attached to the individual incident, as a one-off occurrence. Here we are left wondering whether Rehana's whole experience of racism during her in-patient stay was perpetrated by one individual, or whether the whole nursing workforce on the ward had exhibited the same behaviour.

From observations of the luncheon club it is apparent that Rehana and Farah are both outspoken women, despite their differences, and therefore they were perhaps always more likely to share more intimate and specific details than the other participants. Although they were unique in sharing examples of such explicitly racist behaviour, they were not alone in describing racialised disadvantage in interaction with services.

Muna, another participant, is interviewed with her daughter Salma, who is a professional woman in her 30s, currently residing in another town approximately 50 miles away (See table four p131 for summary). The pair discuss Muna's inability to book herself an appointment with her GP. This begins as a description of a common problem across England, where GPs often operate a system whereby patients must ring early in the morning to book an 'on the day' appointment or expect a long wait if booking in advance. The discussion becomes racialised when Salma describes her own frustration at Muna's frequent contact with her when she is unable to book herself a GP appointment; here Salma starts the narrative in relation to her mother specifically, identifying the 'language barrier that plays a huge role', however she then generalises this; 'I think *they* do get flung to here

and there'. Here Salma is referring to patients that are unable to communicate their needs in English. In order to evidence her claim, Salma goes on to describe a recent occasion when she needed to visit the GP whilst staying with her mother and was able to book herself an appointment without delay, citing that her non-English speaking family members were 'shocked' at this. The family members that she identifies are not just similar in their lack of language skills, but also in their age and gender.

7.2.3 Inequality

The narrative of inequality continues throughout Muna's interview and following a discussion in Urdu, Salma offers three points that each echo narratives in Farah's interview and those of other participants;

1. The reason for unequal treatment is an awareness amongst professionals that the Asian recipients of services will not complain, compared to their white peers, who are happy to do so.
2. Services in 'white areas', a term used synonymously with 'good areas' are better
3. Asian professionals will favour white recipients of their service over Asians

7.2.3.1 Complaints

Salma generalises her mother's struggle to book a GP appointment by extending this challenge to the whole Asian community, she also acknowledges that this is her opinion and not that of her mother;

I personally think it's mainly with a lot of the Asian community they won't complain about it or they won't put anything in about it so it just kind of like gets swept under the mat... there's no complaint, there's no issue risen... it's fine talking about it at home but unless you're going to the right people and mention something about it nothing's going to be done

Here Salma connects her mother's specific challenge with receiving a poor service because of her lack of English language skills, to a much wider problem of not complaining. The inference here is that if the Asian community complained about the discriminatory

treatment they receive due to a language barrier, then improvements would have to be made. She also refers to the common stereotype of the Asian community as sharing 'gossip' between members but not sharing this with 'outsiders'. Salma uses 'they' to refer to 'a lot of the Asian community'; generalising her individual experience with her mother, to other families in similar circumstances despite no longer living in the area. Here we can see how the characteristics of the representational system for Asian community influences Salma's ability to generalise her expectations to others, in line with Hall's theory.

Farah uses an external generalisation to make a very similar point during her interview in a narrative about her adopted daughter's schooling. Farah describes moving her daughter to a school in a 'posh area' because of the better standard of education she believes she will receive;

teacher teaches better you know, the white people goes, and asks the teachers what she's done, how she is, how far she's going, you know, all these questions they ask the teachers, so the teachers have to tell them

When asked whether Pakistani parents asked about their children, Farah identified a difference, along with a rationale for this;

no not much, not many, because most of them they don't know themselves, like me

Here Farah echoes Salma's understanding of the 'Asian community' group identity as not complaining, or actively challenging inequality. Farah generalises both 'white parents' and 'Pakistani parents' based on her own experiences, which although representing Farah's understanding is not necessarily reflective of the average parent.

Both Farah and Salma infer that the problem in these scenarios lies with the Asian community and their failure to challenge discriminatory treatment. For Salma, her mother and her peers should complain about their inability to book appointments due to

communication barriers, and for Farah, Pakistani parents should be more attentive to their children's education. This problematic notion of attributing blame, and that individuals are responsible for improving their situation can be linked to the neo-liberal political agenda of individualism, which is interesting given both women's perceptions of the Asian community as closed off to external influence (see space and place theme).

Reema, another participant (see table four for character summary) has more of a social justice focus when presenting her own narrative of poor care; Reema chose to speak in English, and was alone when interviewed, she also chose not to be recorded, but asked me to write down her responses. She described a recent incident where she had attended her GP surgery for an appointment, during which she had wanted to discuss two separate ailments with the doctor. The GP, not Reema's usual doctor, had refused this request, an action that Reema took exception to, and had wished to complain; 'in my mind I have a big issue, but my daughter she say leave it'. Here Reema identifies that the blame here should lie with the doctor, in opposition to Farah and Salma, who allocate blame with the 'victims' rather than the 'perpetrator' of the discriminatory behaviour, however is discouraged from complaining about this by her daughter in law, who had attended the appointment with Reema.

The incident Reema described was not presented as racially motivated, she identified the GP as 'Asian' and that 'just I spoke to her' rather than her daughter in law being required to interpret. This difference in circumstances means that direct comparisons to the racially motivated discriminatory treatment described by Farah and Salma are not possible, but Muna's daughter in law's reluctance to pursue a complaint about poor treatment do lend support to their presentation of the 'Asian community' as accepting of inequality. This also reinforces Farah's belief that Asian professionals offer a poorer response to Asian patients than their white peers.

Contributing to this subtheme is evidence from the narrative provided by Sayida (see Table four for participant summary). This participant was interviewed with her daughter to interpret and her husband present throughout. There was a much more formal feel to the interview, and Sayida was notably less relaxed than other participants with her and her daughter providing short answers to any questions. Despite the short answers, the family stated that they are happy with the limited contact they have with health and social care

professionals, indicating that their only issue had arisen during a period when their family doctor was on holiday, meaning they had been required to wait longer for an appointment with him.

During the interview Sayida described being in a significant amount of constant pain and detailed her attempts to receive help to ease this. Initially Sayida had visited her GP and received injections in her legs but this had been unsuccessful. Here, Sayida, through her daughter, describes her response to this failed treatment;

Yeah, she's had that done as well, you know where they put, er, needles in? [...] acupuncture, yeah, she's had that done as well, she actually paid for that [...] private year, just to relieve the pain, 'cause she was in a lot of pain

As it becomes apparent that Sayida has paid privately for acupuncture, she is asked whether the doctor had offered this treatment, this is her response;

the doctor said, he said the physio would probably arrange it, but I can't do anything about that, so my mum went privately then thinking that then she might as well spend a bit of money and get it a bit quicker

Here we see that the doctor's ambiguous response lead Sayida and her family to pay for private care, rather than challenge the GP by asserting the need for a referral. The statement that 'I can't do anything about that' indicates the GP failing to explain the process, or the rationale for denying this provision to Sayida with the use of the ambiguous 'probably' signifying a lack of knowledge and valuing of Sayida's needs. The response of the family can be seen in comparison Salma, who, living in a 'white area' and capitalising on the perceived benefits of this, and is prepared to complain and challenge authority in order to seek out fair treatment.

Here Farah, Salma and Sayida's narratives present a generalised assumption that poor service is the result of the expectation from professionals, that Asian community members, specifically those that don't speak English, will not complain. Reema's narrative contributes to this understanding, as despite her awareness that she has been poorly

treated, her daughter in law, a local resident from the same 'Asian community' discourages complaint. Farah and Salma all appear to accept that the blame for enabling this discriminatory treatment to continue lies within the community itself, with only Reema resisting this victim-blaming narrative. The implications of these assumptions are explored later in the chapter.

7.2.3.2 *White = Good*

Discrimination and racist behaviour are not the only way that inequality is presented in the interviews, participants also explored their assumptions about white privilege, a theory described in chapter four. For some this was explicit in their narratives, and for others it became apparent during the transcript analysis.

Several of the participants explicitly used the term 'good' as synonymous with 'white' throughout their interviews, in relation to health and social care services, and state institutions more broadly.

If we return to Salma, and the narrative of her mother's unsuccessful attempts to book herself an appointment with her GP, we see that Salma understands this as racialised. She describes her success in securing an appointment in her own locality here;

I live in a dominantly white community, wherever I am, and I know if there's a problem they'll address it, you will complain to the right authority... and you will make sure that the awareness is risen, but I find with *these* surgeries it's not

Salma goes on to describe how she is able to transfer this learning about the importance of complaining, to the activity of booking an appointment for her mother, and is successful here too, to the surprise of her relatives. Her performance here has a dual role, as it enables her to 'show off' her success in comparison to her relatives, both in terms of her social climbing and her ability to successfully support her mother. To summarise, Salma's performance of self includes her residence in a 'white area', indicating that for her this is perceived as holding higher status than the Asian community where her family remain

located. She also presents a clear link between this 'white area' and the quality of service provided, relating this back to willingness to complain (explored further in the next theme).

Farah continues this synonymity between white and good in several of the narratives within her interview in relation to health and social care services, education and area of residence. Early in her interview Farah provides a narrative of doctor's receptionist she knows, describing her as 'so good you know, happy, smiley, every time you went in...', she continues to explain how important being greeted by such a positive receptionist is when you're feeling unwell, before concluding the story with the following;

She's working in ** (white area) somewhere and she said 'I'm happy' because the GP was Asian and there it's all, you know if you go to white people's surgery it's really good, it's nice yes they're very polite

Here we can see Farah's typical style of trying to avoid direct negative comments about the Asian population (described in the last chapter) in her pause before declining to conclude with what is wrong with 'Asian surgeries' and instead offers the positive attributes of a 'white people's surgery'.

This extract clearly indicates that for Farah a connection exists between 'good surgeries' and 'white surgeries', with her acquaintance, the receptionist choosing to seek alternative employment due to this disparity. The naming of the new surgery's location also indicates a generalised assumption about 'white' space which is discussed further in the 'space and place' theme. The use of present tense here; 'if you go to' indicates this is a generalised statement, Farah is not just telling me that this particular surgery is good, or that it is a coincidence that it is in a 'white area' but that *generally* for her there is a link between quality of provision and the ethnicity of the patients/residents in the area.

When asked directly whether she is referring to the ethnicity of the doctors at the surgery, or the ethnicity of the patients in the local area Farah gives more clarification;

it's the area that it's in, you know, if you go further up its very posh area

This clarity indicates that for Farah, white privilege is in operation irrespective of the ethnicity of the professional providing the service, in this instance the GP. She also uses the term 'posh', here, which is later linked to 'white' through Farah's discussion of her daughter's school and its location. Farah's assumption here is that schools in 'Asian areas' don't provide the same standard of education as those in 'white areas', as described here;

I don't like the school myself because... there's more Asian people's children, they don't teach them right...

As discussed previously this assumption is connected to the perceived reluctance of Asian parents to complain, because of their lack of understanding of English education. The use of the pronouns 'they' and 'them' here indicate the generalised nature of Farah's understanding.

Here Farah's privilege is apparent, she understands the socio-economic division within the town, and how this interacts with ethnicity; she and her family live in a 'white area' and as a result can reap the benefits of this. Farah's educational and socio-economic privilege means that although she sees the inequality, and generalises this across contexts, evidenced in her discussion of both doctor's surgeries and schools, instead of feeling this inequality as part of the 'Asian community', she utilises her knowledge and moves her daughter to a 'white' school, and relocates to a 'white' surgery.

Reema, in comparison to Farah, has a similar understanding of the white privilege operating within society, and the impact this has on her peers, but has a much more social justice orientated response to this discrimination. Reema concludes her interview with the following statement;

This (service) is not in Asian area, if it is in town, not Asian area, Asian women will not go, look at Community Centre, this is only place, can't speak English, we want

more services, we want learn English. English women up here (lifts hand high) Asian women here (lowers other hand) we want, we want equality

Her understanding of inequality and discrimination here is generalised, she doesn't specify a service, but implies that irrespective of the type of service, Asian women will not travel out of the area to access it, therefore generalising this statement. She also recognises the lack of provision for her and her peers; 'this is only place', in comparison to white areas, where she perceives there to be a comparable abundance of support. Reema uses the pronoun 'we' to describe Asian women in her narrative, in contrast to Farah's 'they' and 'them', this indicates Reema's positioning of herself as alongside her peers; she lives in the same area as them and is dependent on the same limited services.

Farah and Salma are both physically and, as we see from their use of the pronouns 'they' and 'them', emotionally removed from the 'Asian Community' they describe. They are however, due to their educational and socio-economic privilege, able to communicate the institutional discrimination they observe. For them, 'white' is synonymous with 'good', as it is for Reema and despite their differences, each of the women recognise the disadvantage that the Asian community face.

7.2.3.3 Asian Professionals and White Recipients

Some participants extend their understanding of racial discrimination further than identifying racist treatment and white privilege in interaction with both institutions and society. They describe more specifically the discrimination they face from Asian professionals. Farah and Salma 'call out' these actions explicitly, as the focus of their narrative, whereas Rehana includes this behaviour as part of a narrative of poor care.

As described above, Salma is Muna's daughter, and attends the interview to interpret for her mother. What is presented is a co-construction of Muna's experiences and Salma's understanding of this, using her perspective as an 'insider' who has moved 'outside'. Included in the narrative discussed above, where Salma and Muna describe the challenges of booking an appointment, and the influence that the ethnicity of the GP practice's patient population can have on the quality of service, is the following extract;

Some of the GPs themselves are Asian as well you know, they're not all, they're all different but she says that she finds that when she goes to a, you know a dominantly English GP (chuckles), they actually take more care of them than the Asian ones will, which is crazy, yeah

Here we see Muna's understanding that she is more likely to receive good quality care from a white GP. Despite both Farah and Salma's claims that the ethnicity of the local population has more influence over the quality of care, here the explicit belief is that the ethnicity of the GP *and* the ethnicity of the patient *in interaction* have an impact on quality.

Linguistic devices evident in the extract indicate that this is not a comfortable narrative for Salma to interpret, she delays the statement with stop-starts; 'you know, they're not all, they're all different' and 'when she goes to a, a you know' before making the accusation. She chuckles with discomfort and adds 'which is crazy' as her closing statement, indicating that she understands this as contradicting an expected system of representation.

The use of pronouns in this extract identify that Muna is relaying her own understanding, with Salma choosing 'she' to refer to her mother's experiences, this is then generalised when referring to the doctors with use of 'they' and 'them'. This indicates that it is Muna's experience of doctors generally, rather than a reference to one specific incident or doctor.

In her interview, Farah makes this expectation explicit, in a generalised narrative about racism in the local area, she presents the following;

Tesco's got Asian people, security guard, and the, it's, he'll be more nicer, nice to white people than you know, their own thing but with the white people they are, they are really nasty to the Asian.

Here Farah clearly presents her understanding of discrimination against 'Asians' by another Asian person. Her reference here is the security guard in a local supermarket giving preferential treatment to white customers over 'their own'. This statement shows Farah's expectation, similar to Salma's 'which is crazy', that primary identifiers such as ethnic identity should receive more loyalty than the subjects of their narratives offer. Farah also

generalises this individual experience, starting with ‘he’ll be’ in reference to the individual she has witnessed, before broadening out to ‘their own’, ‘white people’ and ‘the Asian’, indicating her application of her learning from this experience to society more generally.

Both Muna (and Salma) and Farah made the decision to present this information to me as a specific part of their narrative, but other participants also indicate in a more implicit way, their experience of racism from an ‘Asian’ source.

Rehana includes this in her narrative of poor treatment from interpreters during hospital visits. Although the primary objective of the narrative she presents relates to the discriminatory treatment she receives at the hospital, part of this narrative includes the ethnicity of those perpetrating the racial discrimination. On two occasions described in detail, the interpreter employed by the hospital mocks Rehana’s intelligence; ‘she won’t understand what you’re saying’ followed by ‘she says she speaks Urdu, but she doesn’t understand *me*’ and finally ‘the doctor and the translator started laughing’. Here we have to make an assumption that the professional interpreter is herself Asian, we are aware she is a woman from Rehana’s reference to ‘she’, and from my contextual knowledge, having worked as a social worker in the hospital Rehana refers to, I can be confident that this is likely to be the case. For Rehana this treatment has a generalised impact, she ‘feels ‘really down and embarrassed’ about the specific incidents in the narrative, and ‘doesn’t feel like going’ to her appointments more generally, as a result.

7.2.4 Implications

Close examination of the transcripts has enabled identification of generalisations made by many of the participants about the racism they experience. These are made both within and between professions, and are transferred from one experience to the next, shaping the women’s expectations of the people they interact with and therefore their responses.

These expectations appear robust and remain even when the women identify experiences that contradict their presumptions. Farah for example presents a long narrative about a helpful police woman who supports and reassures her when a foster child runs away but returns to her discourse of expected racism when describing an event where an Asian male friend is pulled over by the police. The persistence of this expectation despite

contradictions indicates that a group identity, or representational system about professionals has developed. In chapter four, Barth's work is presented to explain how social group identities develop an existence independent of their members, therefore one member of the 'professional' group can contradict the representational system that defines it, without this damaging the existence of the system itself.

The result of this racist treatment, both explicitly and implicitly identified in the narratives presented, is explored in the next, interconnecting theme; the expectation of poor care.

7.3 The Expectation of Poor Care

As explored above, many of the participants described experiencing racism and racialised treatment in their interaction with the public, with institutions and with health and social care staff. Participants dealt with these incidents in different ways; Farah was able to 'other' the racists by using her own privilege and capital to separate her from the perpetrator and utilised the preferential treatment she perceived 'white areas' to offer. Rehana internalised the racism she experienced in hospital, contributing to her low self-confidence, and, as this constituted the majority of her interaction outside of the Asian community, this manifested itself in her increased reluctance to travel. Reema was frustrated by the inequality she witnessed, and more so by the pressure to conform to a social norm of passivity. Finally, Muna was disempowered, deferring to her daughter Salma to arrange her health care appointments, to Salma's growing exasperation.

The result of this discriminatory treatment was a generalised assumption from the participants that they should expect poor care. Many of the participants not only described incidents of experiencing poor care, some of which are described above, but extended their narratives, either explicitly or implicitly, to indicate that they expected their care to be poor. In some cases, these expectations were related directly to the racialised discrimination the participant had received previously, but for some, the poor care they expected or received, was not understood as racially motivated. This theme therefore has clear links to the previous theme, but examines specifically the *expectations* of participants.

The expectation of poor care can be subdivided into three different explanations given by participants and their family members. These are defined and explored in more detail below;

7.3.1 You're letting them get away with it

As described in the previous theme, two of the participants (Farah and Muna/Salma) explicitly identified that in relation to both doctor's surgeries and schooling, they expected the service to be poor due to racialised treatment of the Asian community and the expectation that Asian patients, or parents wouldn't complain.

The underlying assumption here is that professionals (here both teachers and doctors) only perform their roles well because of the consequences of not doing. For Farah, teachers do a good job in 'white areas' because white parents are forthcoming in demanding updates about their children's education. Farah and Muna both understand 'white surgeries' as providing a better service, with Farah and Salma, using their own privileged experience of attending a 'white surgery' to justify their assumptions. In both interviews, these beliefs return to the expectation of passivity from the Asian recipients of the respective services, explained by the understanding of group identity and systems of representation described in chapter four. Salma extends this even further to imply that the 'Asian community' are at fault because they don't complain, and are therefore enabling this discrimination to continue, again using her own privileged experience to substantiate these beliefs. The link here between privilege, capital and the tendency to allocate blame for the racialised experiences with the recipients of these experiences is explored further in the 'intersectional oppression' theme.

Relating quality of care provision to fear of consequences, overlooks the understanding that professionals are employed in caring roles to provide services to the public and are driven by values, instead, this narrative underpins their motive for performance as fear related. This is evident in Rehana's description of the nurses during her in-patient stay ignoring her until the consultant was present; the consequences of being recognised as providing poor care by someone with more symbolic capital was the motivation for the nurses to improve their treatment of Rehana, from her interpretation. Broadening this

assumption out indicates that the poor treatment offered to Asian patients is a result of their perceived lack of power to respond.

In England, doctors, nurses and teachers, like social workers and all other registered professionals, are bound by a code of conduct that includes practicing within ethical boundaries (for example HCPC 2016; Nursing and Midwifery Council 2018 (online) General Medical Council 2013 (online)) however this is not recognised in the narratives presented by the participants. This could be due to participant's lack of knowledge of these registration requirements, or a presumption that these values are not respected or upheld by the professionals they interact with. Rehana, for example describes a narrative of a social worker breaching confidentiality when discussing a client on public transport, and both Rehana and Yasmin are conscious of sharing personal information with professionals due to their fear of confidentiality breaches; Reema declined to have her interview recorded for this reason. The examples of breaches of ethical codes from the participants' narratives mean that it is unsurprising that they see these, if aware of them, as lacking credibility and participants and their families attempt to manage this expectation, as described in the following subtheme.

7.3.2 Take backup

In response to the expectation of poor care, both racialised or not, some participants described taking a family member to appointments to support them. Two participants' narratives about this decision are particularly powerful and worth considering here;

Yasmin is escorted to all her health care appointments by her son Mohammed, this is confirmed with him during the interview. Yasmin and Mohammed present one specific narrative of poor care provision but this is not racialised, rather, the story relates to Yasmin's experience of a particularly aggressive treatment by her GP. During the appointment the doctor shakes Yasmin's legs which causes her a great deal of pain. Mohammed was present for the appointment and included his own views on the treatment in the co-constructed interpretation of his mother's interview;

I have always been there and looked after her you know, see what they're saying, what they're doing, maybe if they did something right, something wrong like...

Here the implication is that Mohammed needs to be present to ensure his mother's safety and quality of care, that this isn't assured because of the doctor's adherence to an ethical code and it requires support from him. From Mohammed's perspective, his position of privilege as an English-speaking male, positions him as able to provide the support required to ensure safety, again connecting receipt of poor care to perceived lack of capital. A generalisation is made here from the one bad experience, to the use of 'they', broadening out the possibility of poor care provision to all healthcare professionals.

Alongside this aggressive treatment for her physical illness, Yasmin has received support for her mental health from two separate services; a group counselling session and a psychiatrist. Mohammed and Yasmin both indicate that they were unhappy with the counselling sessions and when this is explored further, the pair present this dissatisfaction as a result of the professional running the session refusing to allow Mohammed to interpret for his mother. The group session provides an independent interpreter for Yasmin, and although this requirement doesn't concern Yasmin, the lack of respect this demonstrates for her son makes her uncomfortable. Further into their narrative, when comparing the counselling session to the psychiatrist's approach to supporting Yasmin, it becomes clear that another variable influenced their unhappiness at Mohammed's denial of access to the counselling session; the necessity for Mohammed to be present to support his mother and ensure the quality of her treatment;

and I was there as well, and then you're seeing inside and the counselling, he was very, very good

Here part of Yasmin and Mohammed's definition of a 'good service' is the inclusion of Mohammed in the appointment, in order to monitor and influence the outcomes; again, they perceive Mohammed as able to exert influence due to his privileged position and possession of capital compared to Yasmin. This influence is seen as a positive by the pair

but is one of the reasons that NHS services demand an independent interpreter be available, as discussed in chapter five.

Rehana, in her interview, is unable to recall a single positive interaction with health and social care professionals; 'no, there haven't' she responds when asked about good experiences directly. For Rehana this is a notably short response compared to the elaborate narratives provided of the poor care she has received.

Rehana's interview is interpreted by her friend and neighbour's daughter Ali and her neighbour Tasleem is also present during the recording. During the interview, the conversation turns to the positive outcomes from Tasleem's engagement with health professionals. Ali describes her understanding of the different experiences of the two women;

that's because we go with her, that's why, we go with her that's why she (pause)
they can't (pause) she's got backup ant' she!

Here Ali is speaking to her sister who is also present, and is presenting her understanding rather than her mothers, signified by the lack of discussion before her comment. She displays similar linguistic techniques to the other participants and interpreters when struggling to find a way to present information that is controversial; pausing, stop-starting and self-correcting while she thinks of the appropriate way to present her thoughts. Ali's relatively young age influences her final choice of words (she is in her late teens, and one of the youngest interpreters); 'she's got backup ant' she'. Here Ali is presenting her understanding that her mother has received good treatment because her and/or her older sister escort her to appointments. The choice of the word 'backup' is interesting and reinforces the idea that her mother, with her perceived lack of capital, would be unable to stand up for herself in the face of the expected poor treatment, and requires support from her daughters; with their youth and English language skills contributing to their elevated position in relation to their mother.

The two examples from the interviews illustrate one way that families have attempted to manage their expectation of poor care themselves. Despite some participants and their

families (see Farah and Salma's narratives above) placing the blame for the continuation of discriminatory treatment with the Asian community themselves for not challenging inequality, when this treatment relates to their family, it is managed by escorting the participants and monitoring their treatment to ensure it is adequate. Again, responses appear to be generalised, with the experiences and expectations of poor care in one institutional setting being transferred across and within professions, with family members opting to escort the participants to all appointments in response to this expectation.

7.3.3 Low Expectations

Some participants did describe positive experiences of interaction with health and social care professionals, however further analysis of their narratives indicate that although they describe satisfaction with the services provided, there were often problems with the provision that were not acknowledged as a negative experience, this is described here as 'setting a low bar'. This is the idea that although the participants were happy with the support they received, this can be seen as a result of low expectations, rather than because the support was 'good' from an outsider perspective. The following example from Safina's narrative illustrates this sub-theme.

Safina describes her positive experience as connected to her ability to communicate with the professionals she encountered during her hospital stay in English. Here we consider whether her experience, although subjectively described as 'good' and not having 'any complaints', was of a standard that is expected of health care professionals.

Safina's health condition is incredibly serious, she has been in and out of hospital several times over the last few years due to heart failure, had to be resuscitated on many occasions and has undergone extensive surgery to try to improve her quality of life. As a result, the follow up care she receives on discharge is also important to ensure her wellbeing once she returns home, yet the narrative she and her son provide includes many failures on the part of the services she is supported by. Safina begins by explaining, via her son Hamza, that she was expecting someone to visit her at home;

H: she goes there's one part where I think a nurse stated to her that she would come and visit, they're to come for her to have some regular check-up or something regarding the heart

S: Punjabi

H: yeah apparently it's not a nurse it's someone else but someone's meant to come and help her out basically no one's been and she stated her, she had her contact details as well, the person that give it her like

Here we see that Safina and her son Hamza are not clear about the profession of the individual due to visit, which indicates that, despite Safina's high level of English language skills, the information has not been made clear to her. This is not presented as a racialised issue and is not recognised as a poor experience by the pair but does indicate that the information was not relayed in a way Safina was able to understand, an aspect of discharge planning expected (NICE 2015). Additionally, we see here that since Safina's discharge, there has been no contact to organise the planned visits. Safina adds that the hospital staff had her contact details, as if discounting this as a reason for the lack of contact, indicating she had been considering this issue.

Despite this poor care, Safina maintains that the support she has experienced is good and has no complaints. This continues as the narrative extends to reveal that this is not the first incident of poor follow-up care, describing an incident a few years earlier;

she, a nurse like, gave her contact details *pause* we tried to contact them, but they wouldn't call back, we did the voicemail like two, three times and they didn't call back either regarding like they were going to come home and that

Here Hamza describes trying to contact the service repeatedly with no success, adding that they had attempted contact several times. The narrative of failed follow-up is repeated throughout the interview, indicating that this is important to the pair, but despite this obvious failure on behalf of professionals, they maintain that they were happy with the support provided. This links to the sub-theme described above, where Farah and Salma both identify passivity in response to poor service as a racialised response. Here Safina and Hamza do not acknowledge any racialised aspects to Safina's poor treatment, in fact they

use Safina's English skills as a rationale for the good quality of care provided in the hospital setting, suggesting that this is identified as a positive position, however their response does fit with the generalised behaviour described by Farah and Salma.

There are challenges in accepting this interpretation of Safina's experience, it may be that my perceived position of power encourages a positive response, despite such self-identified evidence to the contrary but from our interview, and other personal details Safina shared about her very serious physical health issues, it would appear out of character for her to consciously withhold her view.

In connection to the themes, it is apparent that despite stating that they have received a good service from health and social care professionals, in this case the GP, there is scope to interpret Safina's experience differently.

7.3.4 Implications

In this second theme, the expectation of poor care, we can see how the three subthemes interlink within the narratives provided. Several participants' narratives included all three subthemes; identifying not just the expectation of poor care, but also giving explanations for this, and utilising relationships with family to form a response. It is important to take this theme seriously, in a time of austerity where funding for provisions is scarce, a lack of complaint or 'noise' around issues can mean that the issue is overlooked. If the Asian population are overlooking poor care, either because of low expectations, lack of power to respond, or by meeting this with familial responses, this provides an opportunity to avoid an institutional response. Allocating blame for this with under-privileged communities themselves is unhelpful, and in line with Krumer-Nevo's (2016) poverty aware paradigm, those in positions of power and privilege could and should use their influence to enable and facilitate change.

7.4 Space and Place

This theme can be understood in the context of Jenkin's (2014) theory that identity is generated socially, in interaction with the environment and other people, and is most powerful at the borders that exemplify what we are not. This aligns with Goffman's (1958)

exploration of stigmatised identities, and Hall's (2013) systems of representation which explain the processes that both generate and perpetuate them. These theories were discussed in depth in chapters four and five.

The relationship to space and place within the narratives presented by the participants is most often evident in reference to the concept of the 'Asian community'. Here we explore what constitutes this 'community', whether there is a collective understanding of this construction and how this relates to the support offered by health and social care organisations.

Each participant made reference to the 'Asian community' or the 'Pakistani community', but the understanding of what is meant by this term is not entirely collective. As with all constructed realities, there are consistencies in the meaning ascribed by each person due to their own similar life experiences and characteristics, but differences become apparent when analysing the narratives of each participant. Chapter four outlines Barth's understanding of communities as group identities that develop an identity external to that of their members; as a symbolic representation of members' similarities. Acknowledging that communities are a constructed entity, connected to but not synonymous with their members, can explain the varying understandings presented by the participants.

The amount of physical space that each participant was able to experience differed significantly based on factors such as socio-economic privilege and familial support. For example; the physical space accessible to Farah had a much larger radius than the other participants, as her economic capital enabled her to drive independently, a privilege not without challenge. In comparison Rehana was unable to leave her immediate surroundings often, due to limited resources and a lack of familial support. This is explored in more detail in the next themes, but is relevant here to indicate the different positions the participants were located in.

The idea of a boundaried space is presented by many of the participants, but most notably by Mohammed, who interprets for his mother Yasmin, and Salma, who interprets for her mother Muna. Both of these family members refer to information about services 'not getting out' to the community, a word choice that indicates a boundary that the information must penetrate to 'get out'. This use of metaphor by these two particular

family members is interesting and is discussed further later in the chapter. The theme is divided into three subthemes.

7.4.1 Safe versus unsafe

The idea of a bounded community is extended by the participants in their narratives relating to the geographical location of the health and social care services they access. The services are divided between those that are available in the 'community' and those that are 'outside', with the former being seen as 'safe' and the latter, in comparison, as 'unsafe'. There is a connection here with the earlier themes, where several participants identify that services populated by predominantly Asian patients, or pupils (in the case of Farah's school example) are understood as poorer quality, an understanding accepted to be true by the participants. Despite this expectation of a poor service, support that was offered within the community was clearly favoured by those women who discussed it in their interviews.

Farah describes the safety of the Community Centre towards the end of a narrative account of being racially abused in a hospital waiting room;

it's not nice, but you know that's why the old ladies, it's very local, the community centre, it's local, if anything goes there they'll go there, they'll come there... because it was local, and they knew it was not somebody, you know, third person's gonna come in and shout at you anything, abusive, but you do get this

In the extract above Farah makes two points; primarily that for older, female Pakistanis, proximity to the home is of key importance when accessing a service, but also, that the CC is seen as representing a safe place where 'they knew' they would not experience racial abuse. Salma's description of the CC as 'key, because it's where a lot of these people go' lends support to Farah here also. Farah ends her sentence with the confirmation that 'you do get this', referring to racial abuse, when accessing services outside of 'the community'. Here she is explaining that this is a real fear for the women, as racial abuse does happen.

Although the safety of the CC is presented positively by Farah and Salma, with the almost exclusively Pakistani membership offering its members reassurance against racist abuse, Reema presents a different perspective. In her narrative of inequality, she states that 'no-

one comes', referring to the lack of external support. Reema describes the classes that have previously run at the centre, and the need for these to be extended for the members. Muna also raises this point, requesting that more classes be added, or speakers be invited.

The two perspectives presented are not mutually exclusive; the safety offered by the CC both in its proximity to the member's homes and the mostly Pakistani membership (although ethnicity was not a requirement for becoming a member) were valued by the participants, but they were simultaneously able to acknowledge its shortcomings and offer suggestions to extend the centre's remit. They saw broadening the services available locally as the solution to their low expectations of provision, indicating that broadening their sense of safe space to include services further afield was not a consideration.

In contrast to the safety of the CC, many of the participants also presented their opinions about other services in their narratives. Reema encapsulates this contrast most explicitly in her interview;

Where is this service? This is not Asian area, if it is in town, not Asian area, Asian women will not go, look at community centre, this is the only place

It is evident from this extract that Reema has a clear sense of a physical boundary between 'Asian areas' and 'non-Asian areas' and feels able to generalise her response to all 'Asian women'. This assumption generates a sense that Reema experiences the boundaries she describes as fixed and therefore she presumes a shared understanding.

Evidencing Reema's statement is Muna's narrative, which also includes reference to services in 'town', with Salma describing her mother's response;

it's not just the place that she uses it's the locality of it she prefers *text removed* she'd go with somebody, she wouldn't go on her own, she wouldn't be confident enough to

Salma establishes the familiar requirement of proximity, asserted above by Farah and Reema. She explains that 'locality' (taken to mean how local it is to Muna's home) is taken

into consideration alongside the type of provision offered. This balancing of priorities between proximity and appropriateness of or need for a provision has significant consequences for the commissioning of new services to meet the needs of this population and is explored in more detail in the next chapter. Muna extends her statement to explain that she would go to 'town' but not alone, an indication of implied risk in leaving the 'community', particularly in relation to the town centre.

One participant, Rehana, had little choice but to travel outside of the 'community' for hospital appointments. Due to her low socio-economic status and lack of family support, she also had to travel alone by public transport. Rehana experiences this journey as a challenge and she returns to the issue several times throughout her interview. The first reference to travel; 'sometimes she has to go as far as Manchester', presents Rehana's perception of the local city as a long distance, the word choice; 'as far as' is expectant, loaded with the presumption that I will be shocked by the distance she is expected to travel. In terms of physical distance, the city is approximately eight miles from Rehana's home, but this is seen as a significant distance to her, as she refers to it as 'all the way to Manchester' in her next statement. Finally, through Ali she states that 'that is her main concern, going really far on her own', explicitly describing the distance as 'really far' and raising the status of the issue, referring to it as her 'main' concern. Considering the physical distance between Rehana's home and the hospital in the neighbouring city 'really far' away, we can see that the distance is relative to her usual travel patterns and is emotionally connected to the journey that involves moving out of her 'safe' space alone.

The participants shared an understanding of a 'community', although it is unclear whether this is experienced or defined in the same way, each interview included some reference to its existence. There are familiar aspects to the women's narratives that indicate a definite belief in an 'inside' and 'outside', expressed by some in recognising the importance of the 'inside' services and by others in the challenges presented by those on the 'outside'. Despite the safety of the 'inside', this space is challenged, as described in the next theme.

7.4.1.1 Challenges to the 'safe' space

The importance of the CC is indicated in the previous subtheme and it is seen as the central information point for all the participants. At the time of the interviews, the weekly luncheon club had recently been forced to make savings by cutting its subsidised transport. Previously, a minibus had been hired to collect women from some of the local estates, to transport them to the club but this was no longer provided. Five of the eight participants identified this as an issue in their interviews, with three of these women raising it as a concern even though they didn't use the service when it was available.

Rehana, Tasleem (Rehana's neighbour) and Reema had used the transport service but have since had to seek alternative transport to the luncheon club. Rehana and Tasleem now walk to the club, although they describe this as taking a long time. Rehana expresses this in English, as discussed in the previous chapter, this is a device Rehana employs when she wants to emphasise a point;

15 minutes-walk between here and community centre, and, and my friends are going thirty minutes-walk, after it can be 45 minutes, because of slow

Rehana describes herself and her friends as taking a longer time on the return journey from the centre because of a hill they have to climb and given Rehana's physical ill health, a 45-minute walk is a significant challenge. The cut to transport is an externally controlled issue, that the women have had imposed onto them, however Rehana does not appear angry or frustrated about this, rather she appears to blame herself, focussing on individualised deficits and solutions; Ali interprets that the women did not attend the centre on the day of interview because they 'couldn't be arsed walking', blaming their own 'laziness' for not attending, rather than the failure on behalf of the local authority to provide adequate transportation funding. Their solution, to walk, also indicates an individualised solution to the issue, one that is echoed by Reema, who now relies on her daughter-in-law for a lift to the club. Reema also describes the previous transport favourably;

I sit there in my door and they take me, take all of the women

Again, similar to Rehana, Reema acknowledges that the lack of transport is a shared problem that affects several of the women but individualises the solution by recruiting her daughter-in-law when available. This resourcefulness echoes the individualised solutions to experiencing poor treatment in the earlier theme, and also reflects the idea of passivity in response to the agencies that implement decisions that detrimentally affect them.

Yasmin and Muna refer to cuts to transport despite not using this service when it was available. Yasmin's son Mohammed has always transported his mother to and from the centre and Muna has always walked. Yasmin identifies 'four or five women that come from away', who are no longer able to attend the centre as the distance is too great to walk and they have no family available to drive them in the daytime.

When I first attended the luncheon club it was summertime, and there were often at least twenty women attending each session, however as the weather worsened the attendance dropped significantly. The few that continued to attend through the winter months explained that the weather made it difficult to attend because the transport was not available, and many women walked to the club, an activity that became too difficult during the bad weather, particularly for those with poorer health. This means that the cut disproportionately affects those with poorest health, no personal transport (those with low socio-economic status) or no family support. It also has significant implications for service provision as reduced numbers can be interpreted as meaning that a service isn't required or is failing to meet the needs of the population. The number of attendees at the luncheon club has been constantly under review by the council throughout this thesis, with the implication that if the numbers were low, the subsidised provision may also be cut.

Muna and her daughter indicate their complex understanding of community when expressing the requirement for transport, with Salma asserting that 'it's alright for her, it's down the road, but anyone coming from other communities...' Here Salma refers to 'other communities' in reference to other estates with a high Pakistani population. This indicates that although for Salma at least, there is a sense of 'Asian community', discussed in the first subtheme, there is also a distinction drawn between the different Asian 'communities' based on their geographical location in the town.

This complexity is not the only difficulty in attempting to ascertain what, if any fixed description is able to, constitutes community for the participants. The following subtheme explores the contradictions and complexities of understanding space and place.

7.4.2 Complexity

Attempting to understand the different participant's experiences of community and how they define themselves in their space and place is challenging but important in order to ascertain how this has an impact on service provision. Reference to space and place, particularly in relation to understanding what constitutes the 'Asian community' appears to have an impact on how and whether services are considered, but the expectations that participants present are often contradictory, adding an additional layer to analysis. Here I explore examples of contradictions presented by three of the participants in their narratives.

Throughout her interview, Rehana discusses her attendance at many different support services, including several counselling and early help groups in relation to her mental health. The location of two of these services is significant in furthering our understanding of 'safe' and 'unsafe' space and present a challenge to earlier subthemes; Rehana describes a group counselling service at a well-known local authority building 'in town'; 'they were nice, at XX Centre' where she attended for two years, until the workers explained to her that she had been using the group for the maximum time allowed. This means that Rehana had been travelling independently into the town centre, weekly for two years, a task that both Muna and Reema stated was not a possibility in their interviews. Reema stated very clearly that if services were 'not in an Asian area then Asian women will not go' and Muna described not feeling confident to travel to town alone.

Rehana's willingness to travel to an 'unsafe area' on a weekly basis is not just a challenge to other participant's generalised beliefs about their peers, but also to her own attendance at other venues. Later in her interview, Rehana describes being asked to attend another counselling session, in a much closer area of the town, her response is presented by Ali here;

they used to call from XX (area of town) but she never used to go she said because of the travel distance, the main problem is transport and she can't speak so she can't get there, she can't speak English

Here Rehana identifies the travel distance, and her lack of English language as preventing her attending this relatively local session, whereas she was able to travel to the town centre alone on a weekly basis for two years, an apparent contradiction in her ability to enter 'unsafe' areas. Rehana does not add much detail to these two events, only to indicate that the transport to the group in area two used to be provided, and only when this ceased and there was an expectation that she found her own way, did Rehana stop attending. This contrasts with the service in the town centre, where Rehana had always had to travel to independently, indicating that the change in expectation was more of an obstacle for Rehana than the distance. Rehana's ability to defy the expectations of both Muna and Reema is interesting, as Rehana presents as having low self-esteem and positions herself as the subject of abuse and victimisation throughout her interview (see last chapter), she also has the least capital available to her, of all the participants. It is possible that despite the emotional distress that using public transport to hospitals 'as far away as Manchester' causes, this has increased Rehana's resilience to travelling alone to closer 'unsafe' areas such as the town centre. It is evident that Rehana's understanding of community and safe places is complex and variable.

Reema also presents a complex understanding of moving between 'safe' and 'unsafe' spaces, particularly given the social justice position she embodied during her interview. Reema expressed strongly that she believed Asian women would not travel out of an 'Asian area' to access services and indicated that she didn't feel that they should have to, stating that she would like to see more varied input at the CC. Her understanding of the unequal treatment afforded to Asian women compared to white women was expressed verbally and with hand gestures, indicating the importance of this issue for her.

Early in Reema's interview however, she discusses her overall health in a narrative about an experience of poor care from her GP. Here Reema identifies that she has a heart condition, for which she is required to attend regular check-ups 'to hospital, Xtown Hospital, Ztown Hospital, Ytown Hospital, all the time appointments'. This assertion that

she regularly attends several regional hospitals without concern highlights a contradiction with her belief that it is problematic for 'Asian women' to leave an 'Asian area'. There are several explanations for this; it is possible that Reema is accompanied to the hospital as she doesn't identify how she travels to her appointments, it is also possible that Reema sees herself as removed from the 'Asian women' she groups together in her first point through her access to social and cultural capital.

Irrespective of the explanation for Reema's contradictory statements, there is a connection with Rehana's motivation to travel into the town centre for support here. Both women have managed to achieve an outcome they believed impossible for 'Asian women' in attending a service outside of a 'safe area'.

This contradiction between what the women think they would do, and what they actually do relates back to Jenkins' (2014) exploration of group identity, where he describes Barth's (1969) theory that groups develop their own identity as a symbolic representation of the similarities within the group. Because the group identity is a symbolic representation rather than a representation of the actual members, it enables the members (in this case Reema and Rehana) to contradict the group identity (in this case by leaving the community to access support), whilst preserving the existence of the group identity, which includes preferring not to leave the community.

7.4.3 Confidentiality

For all users of health and social care services, confidentiality is an important factor, especially when discussing sensitive information. It is commonly understood within the national context, that GPs and other health and social care professionals are bound by an ethical code which includes confidentiality, however this is not the experience, or the expectation of the participants. This subtheme describes the women's experiences of breaches of confidentiality, how this influences their expectations and requirements of health and care services and contributes to understanding definitions of 'Asian community'.

Yasmin, Farah and Rehana present narratives that reference interpreters, and their beliefs and experiences of using professional interpreters in health and social care settings. These

experiences contribute to an understanding of 'community' as defined by the ethnicity of its members, and the challenges that this presents for the women.

Within Yasmin's account of her group counselling experiences, she identifies the only factor that influenced her negative opinion of this service as the provision of an independent interpreter. Although this also related to the perceived challenge to Mohammed's position, Yasmin describes her concerns in relation to these interpreters;

yeah other people, she doesn't want other people to know, like the Asian community, majority of them they start soaking this kind of thing up like, it's different and they start like soaking up each other people's life stories and stuff and she doesn't like it, she'd rather be around family

Here Mohammed describes his mother's fear that other people from the 'Asian community' will find out about her mental health needs and will gossip about her. Mohammed's choice of 'they' to describe the community members indicates both the separating of his family and particularly himself from this behaviour and the generalisation of other members' behaviour. The assumption made here is that an Urdu (Yasmin's first language) interpreter would be Pakistani and therefore have connections to the community. When prompted to identify whether the family had experienced knowing an interpreter employed to support them, Yasmin is less specific;

no, some you know, some you don't. Some be local you know like, yeah some be local, like someone's sister

The first response here is 'no', followed up by a more indefinite answer, indicating that the proximity of the interpreter's residence is an important factor; being 'local' or a relative of an acquaintance are highlighted as risk factors to breaching confidentiality. The assumptions that the interpreter will be Asian and live locally suggests that the family's understanding of 'community' is ethnically defined and that this has an impact on the trustworthiness of the interpreter. The implications of this assumption are seen in Yasmin's unhappiness with the service overall, signifying that if local Pakistani interpreters are used

to support patients, their expectations are that confidentiality is at risk, which results in dissatisfaction with the service provision. In addition, Mohammed uses the phrase 'it's different' when describing this predisposition to gossip and share confidential information, suggesting that he believes this to be a problem that is specific to the ethnically defined 'Asian community' rather than a challenge faced across all ethnicities and geographical locations. This statement is added to give clarity to me, a white woman, indicating that Mohammed expects I won't know how the 'Asian community' behave, again demonstrating his perception of an ethnically defined group identity.

In her interview, Farah continues this notion of an ethnically defined community group and the challenge this raises for perceptions of confidentiality. Farah's extensive involvement in children and families social work in order to complete the adoption of her foster daughter means that she has a more comprehensive knowledge of how health and social care systems work in a local context. In her narrative about confidentiality, she explains her understanding of why she thinks professional interpreters are always used;

well, that social worker's going to be Asian isn't it, because a translator is maybe her, back of the village, I know it's your job to protect your thingy, she's not allowed to say anything, but what if she's saying something and telling someone 'don't tell anything' you know, maybe that's why

Farah's narrative contains several linguistic features identified by Riessman (2008) as key to interpreting meaning and denoting important events for the participant. Farah presumes that the social worker and/or interpreter would be female; she refers to the prefix 'she' and 'her' throughout. She also presumes the ethnicity of the social worker as 'Asian', indicating that her experience is of Asian professionals being allocated to her, rather than of white workers who speak a second language, an understanding that reflects the local workforce population. Farah also refers to 'you' when she discusses the social worker/interpreter role; 'I know it's *your* job'. Here there are two possibilities, she may be embodying the role as she describes the consideration she would have to make as a social worker. Alternatively, the 'you' could be in reference to her knowledge that the I, the researcher conducting the interview am also a social worker. Irrespective of this who 'you'

is Farah switches back to 'she' before describing the breach of confidentiality, not wanting to position either me or herself as acting unprofessionally. Finally, Farah uses direct speech from this fictitious scenario to demonstrate how she perceives confidentiality breaches to occur; primarily because Asian professionals tell other people about their work but try to conceal this.

Farah's reference to 'back of the village' refers to an ethnically defined collective sense of community she believes to exist. The use of the term 'village' is a reference to her Pakistani heritage and in other parts of her interview she describes the different towns and 'villages' that the women from the luncheon club originate from. It would appear that for Farah, the behaviours and actions of her early experiences in Pakistan have transferred to the current UK setting, and have contributed to the 'Asian community' she describes here.

The narrative presented by Farah extends Yasmin's presumption that Asian community members will breach confidentiality by adding that these professionals may then attempt to conceal their unprofessional behaviour by requesting the information is not shared, increasing the level of deception. This has broad implications for service provision if services and organisations want to build trust with this underrepresented group.

Analysis of Yasmin and Farah's narratives presents evidence of a shared understanding of ethnically defined 'Asian community', but Rehana's experiences contribute another aspect to this interpretation. Rehana describes several incidents of poor treatment by professional interpreters throughout her interview, but she also includes narratives where she is positioned as an observer, rather than the victim. During these short and specific stories, Rehana includes her experience of overhearing social workers discussing cases whilst travelling by public transport to an appointment;

she goes, get a social worker from out of town because if you get, if you get from Xtown they know you and, in the community they go and talk to someone else about it

Here we see Rehana as much more confident when not describing her own experiences; she firmly tells me her advice 'get a' rather than suggesting this as an option. Rehana

presents herself assertively here; 'they go and talk', this is what they *do*, not what they *might* do, she also uses the prefix 'they', denoting a generalised assumption. In this statement Rehana describes both 'town' and the 'community', with the recommendation to get an out of town worker rather than one from Xtown, a much broader area of concern than Yasmin and Farah suggest might be problematic. This advice makes explicit Rehana's lack of social work systems knowledge, as she is unaware that professionals are allocated by local authority, and therefore she would be unable to receive support from a social worker employed outside of the Xtown area. Neither Ali or her sister, who are both present, correct Rehana, indicating that they are also unaware of this process.

In the extract Rehana also mentions 'the community', here this can be interpreted as the 'Asian community' as referred to by Farah and Yasmin and defined by the ethnicity of its members. This assumption can be made, as Rehana has already defined the broader geographical area as both 'town' and by the town's name, whereas here she scales this down to 'the community', implying a different, smaller area.

There are two implications of this assumption; primarily that if Rehana is allocated an Xtown social worker who was not from the community, the lack of confidentiality between workers would mean that there is a risk of this information being shared with a social worker from 'the community'. This worker is then likely to share information about her to other 'community members'. Additionally, Rehana's understanding may be comparable with Farah's in believing that an Asian social worker would automatically be allocated to her, and therefore there would always be a risk of her confidential information being disclosed. Both interpretations raise important challenges for service provision to the 'Asian community', with Rehana's contribution increasing the scale of confidentiality concerns to encompass all professionals within the whole town.

Rehana extends her generalised assumption described in the extract above by detailing a specific event that has influenced her opinions. The first section of text below is interpreted by Ali, and the second is spoken by Rehana herself, in English;

A: She goes, she heard them on the bus and they be talking about someone 'she said this, and she said that, and she's got this problem'

R: one English girl, and one Asian, together sat behind me was talking to her

The pair laugh about this and then explain that Rehana knew the woman that the two professionals were discussing. This example exemplifies how generalised assumptions are formed from experience. Rehana's experience reflects her opinion that a social worker from 'out of town' is preferable, irrespective of ethnicity because this information will be shared inappropriately with someone from the community. There is also the added risk that other community members will hear confidential information when it is shared in inappropriate settings such as on the bus, as Rehana experienced.

It is evident that concerns about confidentiality have an impact on how the participants experience services, with Yasmin's unease in her group counselling session centred around the insistence on a professional interpreter; both Yasmin and Farah's presumptions that information would be shared about them inappropriately within the community and Rehana's example of experiencing this breach of confidentiality. The expectations of the women in relation to their confidentiality is important in relation to provision and acceptance of services; the use of professional interpreters is a generalised practice in health and social care services. This practice is employed to ensure objectivity in information sharing and, in many interactions, there is a legal duty to ensure this service is both provided (Equality Act) and utilised (Care Act, MCA, MHA), described in chapter five.

The subthemes so far present a challenging picture, as accessing services outside of the 'community' is perceived as problematic, because of residual fears as a result of historical local violence and unrest, transport issues and complex interactions with 'safe' and 'unsafe' spaces. Adding to this complexity is the apparent contradiction between the problems arising from having to travel to receive support outside of the safety of the community, whilst also avoiding the expectation of breached confidentiality that arise from accepting support located within the community.

7.4.4 Implications

This theme presents significant challenges for the provision of appropriate health and social care services to the 'Asian community', primarily due to the contradiction between the

requirement for close proximity to the community, and the lack of confidence in the confidentiality of their information when shared with professionals from within the community. Several of the women did manage to attend services that were located outside of their self-defined safe space, although this was influenced by the provision of transport for some and involved emotional labour for others. The idea of a 'safe space' has to be viewed in the local context of historical violence and unrest between the white and Asian communities in the town. All of the women lived in the area during this period and the residual fear has had an impact on their confidence to enter certain parts of the town. It is possible that rather than attempting to reconcile this contradictory perspective with surface level quick fixes, such as providing transport, or relocating services, that working with the whole town to extend the 'safety zone' would provide a longer term and more sustainable solution.

8. Intersectionality and Capital

8.1 Introduction

Intersectionality, as discussed in earlier chapters, was developed and popularised by Kimberlé Crenshaw (1989) who identified the absence of black women's experiences in traditional feminist theory and provided a platform to forefront exploration of the differing experiences of those living with multiple oppressions. Crenshaw's work is of fundamental importance and transformed both activism and academia. This chapter illustrates how intersectional theory, in combination with Bourdieu's notion of capital, can help us to understand the complex and differing experiences of the participants.

Intersectionality, with a particular emphasis on class difference, was identified as a theme during the analysis, however, due to the significance of its impact on the participants' experiences, a separate chapter has been allocated. Some of the ideas contained in this chapter do appear in chapters six and seven, but the focus in this chapter is the impact of intersectionality. Repetition has been kept to a minimum but there are areas where this does occur in order to facilitate understanding.

All the participants are aged between 60 and 68 years, and all are first generation migrants who self-define their ethnicity as Pakistani. Only female participants were recruited for reasons explained in the methodology chapter and although the male manager of the community centre was also interviewed, the decision was made not to use his evidence, to avoid the appearance of validating female voices with a more privileged male perspective. All of the women had lived in the town for the whole of their time in England but despite these similarities, their narratives presented very different experiences of interactions with health and social care provisions.

As described by Guneratnam (2003), research that focusses on ethnicity often conflates the importance of this factor at the detriment of acknowledging other variables. This highlights the importance of considering intersectionality in the analysis of data, in this case, the impact of socio-economic status is of particular importance. Ill health and mortality rates correlate with socio-economic status (Khan and Shaheen 2017), with the wealthy in any given society living longer and experiencing significantly less ill health across their lifespan.

This pattern is reflected in the small participant sample, with several of the women with a lower socio-economic status experiencing multiple physical and mental health problems compared to Farah who was physically and mentally well.

All of the women self-defined their ethnicity as Pakistani, but Pakistan is a large country which operates its own class system, typically dividing its population between the more affluent, who live in the towns and cities and those who live in rural villages (Mumtaz and Mitha 1996). In her interview, Farah describes this division, and explains the different languages and dialects spoken by the women from Mirpur or Kashmir (rural and agricultural regions) compared to those from Islamabad and Karachi (cities). Farah herself is from Karachi and the ease with which her reference to 'back of the village' is used to describe the potential for breaches of confidentiality through gossip within the 'Asian community' indicates that this stereotype has transferred with her from Pakistan to the UK context.

Rehana's experiences also reference the negative stereotypes related to the Pakistani population that originate from rural villages. In her narrative of poor care provided by the hospital interpreter Rehana relays the interpreter's direct speech; 'she goes, 'oh she doesn't know, they're illiterate people''. Here the interpreter, who is later defined as 'Asian', generalises her inability to communicate successfully with Rehana to 'they', in reference to Rehana's place of origin in Pakistan and the assumption that people from the rural villages are 'illiterate'. Again, the ease with which the Asian interpreter recalled and presented a negative and stereotyped view of Rehana is evidence of Guneratnam's statement that conflating the importance of ethnicity, and presuming a homogenous population mean that other differences, such as socio-economic status, are not acknowledged.

The participants are all female, and as such gendered differences are not present between their narratives, however their experiences are those of women, rather than representing those of the Pakistani population in the area as a whole. Historically, as explored in the second chapter, women and men's experiences of migrating to, and settling in England have been gendered, with the men arriving earlier to establish homes and locate employment before being joined by female family members, and children (Visram 2003). Employment for those arriving without professions was often found in factories, and consisted of low skilled shift work, often during the night. This meant that these men had

little opportunity to learn the English language, or understand the culture, however even fewer opportunities were available to the women. On arrival in England, they were usually expected to look after the home and children, with most of their needs being met without leaving the streets where the males had purchased homes (Visram 2003, Ritchie 2001). The women participants are all first-generation migrants and as such most followed this pattern of migration from Pakistan in the 1960s, only one participant, Farah, migrated with a more privileged socio-economic status, which is reflected in her fluent English and independent transport.

The role of males as 'protectors' is evident throughout the interviews; primarily Yasmin and her son's co-constructed account of her treatment, where Yasmin's dissatisfaction is with her son being disrespected rather than the impact of the counselling on her own wellbeing. Both Yasmin and her son perform gendered roles, and both are happier when Mohammed is present during treatment, due to his perceived ability to intervene and protect his mother from any mistreatment.

Farah's higher socio-economic status allows her access to spaces that are gendered for poorer women, for example her fluent English and ability to drive independently enable her to interact with a broader section of society. Despite this, she still presents a gendered understanding of roles, and presents males as protectors as she describes the unrest in the town;

The peoples start thinking, if they can go into that lady's house then tomorrow they're going to come into our house, our mum's there, our wives, our children, what happens, that's why they all got together

Here Farah refers to 'the peoples' which is ungendered, however she then lists 'our mum's there, our wives, our children', with the implication that the women and children were at risk, therefore then men 'got together' to protect them. This explanation is cemented with Farah's description of the 'the white boys', and the description of the concerns she had at the time about whether her sons were involved, rather than all her children (Ritchie 2001).

Although intersectional theory requires consideration of the different types of oppression and disadvantages facing individuals and groups, it also warns against trying to create a hierarchy of disadvantage, based on listing oppressions. Essentially, the impact of experiencing multiple oppressions is seen as individualised, greater and more complex than adding together the different demographic groups one could be categorised under. In light of this understanding, this theme is not divided into different attributes that the participants 'possess', although these are discussed, rather, this is a holistic exploration of how the women, individually and as representatives of people experiencing different disadvantages, are affected by their treatment by society in general, and in interaction with health and social care services.

Bourdieu (1989) discusses oppression and disadvantage in relation to possession of different types of capital. This is described in more detail in chapter five, however is relevant here in relation to the privileges afforded to some in relation to their possession of capital. Some participants possess more economic capital than others, but other types of capital are also of key importance here, particularly in relation to understanding how health and social care systems operate. One example is Salma's ability to negotiate herself a doctor's appointment when her family could not, this could be described through her use of cultural capital, or knowledge of how the system operates. Another example is Farah's ability to secure her child a place in the school of her choice through a combination of cultural capital through knowledge of the system, social capital, through her relationship with the social worker, and symbolic capital that comes with living in an affluent area. The remainder of this chapter is divided into subthemes;

- English Language skills
- Managing abuse
- Using privilege
- Complexity of 'in-group' relationships

8.2. English Language Skills

One aspect of the participant's lives that was repeatedly raised as a challenge for them was that of English language skills. Lack of this cultural capital was acknowledged by all

participants as a barrier to independence and even those who possessed this skill identified it as a significant barrier for those that didn't. The ability to communicate in English is multi-dimensional and can be connected to socio-economic group and opportunity, age/generation and gender. Understanding the intersectional aspects of language acquisition enables us to explore how this factor influences interactions with both the public and health and social care professionals.

Two of the participants completed their interviews in English (Farah and Reema), another spoke fluent English but requested that her son interpret for her (Safina) with the remaining four women choosing family to speak for them, and describing their English skills as poor (Rehana, Yasmin, Muna and Sayida). Interestingly, all interjected in English throughout the interviews, despite lacking the confidence to participate in the interviews independently. The use of English was strategic for many of the women and was often used to reinforce a point they had already expressed through their interpreter or to steer the conversation.

Throughout the interviews, the possession of English language skills was related to intelligence and the receipt of a higher standard of care, whereas the lack of this skill was associated with fear and inferior intelligence. These assumptions were made by the women themselves and by the professionals they came into contact with, indicating that this understanding has developed into a representational system.

In the very first sentence of her interview, Farah makes this statement;

the other ladies, who you know, like I said they don't know English, they don't know anything you know.

Here Farah refers to the women from the community centre as the 'other ladies', using the prefix 'they' to generalise her assertion to all women who don't speak English and separating herself, as an English speaker. The statement connects knowing English to knowing 'anything', indicating that for her there is a correlation between intelligence and language skill. This is an association Farah makes again when discussing Asian teaching assistants in schools with a high Asian pupil population;

assistant teacher, even they don't know any English *text removed* If they don't know anything how they going to help the children?

Farah again makes a link between 'knowing anything' and possessing English language skills, implying that the teaching assistants have nothing valuable to teach the children, associating intelligence, or knowledge, with language.

Rehana's experience with the hospital interpreter contributes to this understanding, with the interpreter stating 'they're illiterate people'; associating her inability to communicate with Rehana with both her lack of language skills and her capacity to understand the explanation of her medical condition. The term 'illiterate' is heavily loaded, and is not used in its literal sense here, as the interpreter is not asking Rehana to read or write (the generally accepted definition of being 'literate'), instead the term is being used to question Rehana's intelligence.

Both Farah and the hospital interpreter are of Pakistani origin, meaning that this discriminatory correlation between intelligence and ability to speak English is not grounded in ethnicity, rather, this belief is rooted in representational systems of class and socio-economic status, or possession of capital. Farah is of significantly higher socio-economic status than Rehana and despite being a Pakistani woman, has a comparable abundance of capital. Similarly, the interpreter's performance is directed at the consultant, positioning herself as separate from Rehana and choosing to ally herself with the senior medic by insulting Rehana, reinforcing her own capital, as an employed, English speaking woman.

This discriminatory assumption is not unique to these scenarios, or to these women, and the consequences of constructing a person's worth based on their ability to speak English is apparent in Safina's narrative of positive experiences;

because I can speak with them, that's why they understand me, and good service

Here Safina connects her 'good service' to her ability to communicate and continues to explain that she doesn't believe she would receive an 'equal type of treatment' if she was unable to communicate in English. Safina has little economic capital, she and her family live in a small terraced house, her interview was conducted in an undecorated pavement facing room with a small electric heater to warm the modest space, however, she does possess cultural capital in her use of English language, and symbolic capital in her education and profession as a teacher in Pakistan. Using intersectionality and capital, we can see that Safina's socio-economic position, or lack of economic capital enables her to visualise what her experience would be like without the cultural capital of English language. Her consistent reference to her experiences as positive, despite the examples of poor-quality follow-up care show her to be appreciative of the capital she does possess. Comparably, Farah's inability to associate on this level enables her to 'other' the women' and teaching assistants who 'know nothing'.

The implications of this association between intelligence, or knowledge and language possession are significant, indicating that those with least capital and experiencing the most substantial intersecting oppression are also most likely to encounter discrimination, from both within the 'Asian community' and from the professionals they interact with. The outcome has consequences for the participants' willingness to travel outside of their safe space to receive support, as evidenced by Muna, Reema and Rehana, who all express concern about travelling outside of the 'community', with Muna and Rehana relating these concerns specifically to a lack of English language. Muna explains that she would only consider travelling into town accompanied by someone else, stating that she 'wouldn't be confident enough to [...] because speak English problems', a position that is echoed by Rehana, as Ali interprets; 'she can't speak, so she can't get there'. The lack of English language skills acts as a barrier to the women leaving the community to access support and has a negative impact on their confidence. Experiences such as Rehana's encounter with the interpreter mean that when she does find the confidence to travel alone outside of the 'community', her fears are reinforced by the discriminatory treatment she receives, leaving her 'down and embarrassed', 'frustrated', 'unwelcome' and not wanting to return, a cycle that has serious consequences for the physical and mental health of those in oppressed groups.

8.3 Managing abuse

Rehana describes having ‘no good experiences’ of interacting with health and social care, her narratives of poor care are documented in earlier chapters, as is her low socio-economic status and lack of all forms of capital. She frequently mentions not only the emotional labour involved in travelling outside of the community for appointments where she experiences discriminatory treatment, but also the financial implications of this, referring to ‘paying double’ for travelling to cancelled appointments on several occasions. Repetition indicates a point of importance for Rehana and confirms her lack of economic capital. Rehana is therefore experiencing several forms of intersecting oppressions; she is an older, Pakistani woman with substantial physical ill health, poor English language skills and is dependent on benefits as her only source of income. Rehana experiences discrimination, which appears to be based on her ethnic background, but as previously identified, actually stems from a combination of racism and stereotypical assumptions about her intelligence based on her region of origin within Pakistan, she is unable to use her own capital or privilege to counter these attacks on her character. This is because Rehana has little identifiable capital or privilege to recruit and as a result, she appears to internalise the opinions of the source of discrimination. This results in Rehana’s personality being suppressed when interacting with health and social care professionals, as described in the previous chapter in her narrative of poor in-patient care. Rehana becomes withdrawn and attempts to present herself in what she perceives to be a more acceptable way, performing what she believes to be the actions of a ‘good patient’ and seeking to locate blame within herself; ‘what have I done’, rather than focusing this on the source of discrimination.

Conversely, Farah’s experiences of discrimination mark a contrast with Rehana’s in relation to the source of discrimination and her response. Despite both being older Pakistani women, Farah and Rehana occupy significantly different positions, with Farah having significantly more access to all forms of capital; she has an affluent socio-economic position, she has good physical and mental health, her own transport, English language skills, and lives in a middle-class neighbourhood close to her adult children, who all work in professional careers.

Although Farah's ability to travel independently to destinations outside the safety of Rehana's 'community', this is not without challenge. Farah faces racism from the general public and presents several narratives describing these encounters, most frequently she refers to an incident in a superstore car park, where an older white couple used racist slurs to express their shock at her expensive car ownership. Farah returns to this incident several times, identifying it as an incident of importance however she also describes other experiences including being racially abused in another car park, and in a hospital waiting area. The reaction to the first incident relates to Farah's age-related perceptions of racist behaviour, but here we focus on her response. In comparison to Rehana, Farah is able to recruit her own privilege and capital to 'other' the racists and locate blame in their lack of these attributes. Primarily Farah associates racist behaviour with low socio-economic status and connects this to level of intelligence. Here she describes a racist incident in a hospital waiting room;

honestly the educated people they won't mind these things, but you know the people who are little poor, that's white people...

We see Farah contrast 'educated' with 'poor' here, as if these are opposite attributes. In the next paragraph she returns to this theme, describing the source of racist abuse in a supermarket car park as 'this old, this fat man' and 'those kind of peoples [...] big in the weight and the size of the mouth'. Here Farah doesn't explicitly reference the intelligence or socio-economic status of the abuser, but her description of 'those kind of peoples' indicates she is not surprised by his behaviour, compared to the shock when a middle class, middle aged couple address her with the same racist attitude. This indicates that the abuser in this incident conforms to the constructed representational system of a racist as poor and uneducated.

When comparing Farah's response to Rehana's, although she does reflect on these incidents, expressing anger and frustration, Farah is able to separate these from herself; rather than seeking to locate blame in her own behaviour, she utilises the capital that she possesses over the sources of racist behaviour, to 'other' and minimise them; she has economic capital therefore she can blame their poverty, she has an education so she can

focus on their lack of one. The possession of this economic and cultural capital enables Farah to externalise the racist behaviour rather than internalise it. She is enabled to do this both because of her own status, and because the source of racism towards her is from members of the public. For Rehana, her own lack of capital means she is unable to use this technique, especially when she is confronted by discrimination predominantly from professionals with substantial comparable privilege and capital.

This comparison allows us to see how possession of different types of capital can enable individuals to manage discrimination differently, with those with the least capital experiencing the most disadvantage, but that this is not just dependent on the recipient's position, but on that of the source of discrimination. For the women of lower socio-economic status, the racism they encounter is more likely to be from someone in a professional role, as these appointments account for the majority of their time spent outside of the safety of the 'community'.

8.4 Using privilege

The previous subtheme identified that those with more privilege and access to capital were more capable of externalising abuse by way of focussing on the lack of capital available to the source of the discrimination. This theme explores how access to capital enable some participants and their families to use this privilege.

As previously described, Farah and Salma (Muna's daughter and chosen interpreter) describe using white privilege to their advantage. Both share a belief that provisions to serve white populations are of a higher quality and are able to access this quality because of their own capital. Both women have economic capital, which enables them to live in middle-class areas, or 'white areas' as they define them. Their cultural capital, here knowledge of health and social care systems means that they are able to negotiate and secure services for themselves. Salma describes her ability to book a hospital appointment as a visitor to the area;

like my sister-in-law, who's isn't first English language, my mother who's is not English, they were quite shocked, and they were like 'wow you're out of town and you've already got an appointment'

In the extract, Salma compares her achievement to that of her mother, who is an older Pakistani woman with physical health difficulties and little English language and also to her sister-in-law, who is of a similar age and unlike Salma has not had access to English lessons or been able to move away from the local 'Asian community', therefore not achieving the privileged status Salma has assumed. The use of direct speech in this narrative and the transgression from her interpreting role indicates Salma's pride in this achievement, her desire to present an idealised self sees her position herself as successful, and her understanding of successful.

Similarly, Farah describes the relative ease with which she secures a school place for her daughter at a school in a 'white area, very nice area' by accessing her social capital and recruiting the support of a social worker. Farah's knowledge of the school's duty to accept her daughter because of her adopted status demonstrates how, through the combination of social and cultural capital, she achieved her desired outcome.

It is therefore, those with socio-economic or cultural capital that are able to understand this comparison between services in white areas and those in the 'Asian communities', with those from the community having no experience of 'white services' to compare their own encounters with. Farah and Salma both live in 'white' areas with Farah having an understanding of the social work system due to her daughter's adoption and Salma's working-age, language skills and residence in a 'white' area giving them increased cultural capital to negotiate and understand the inequality and use this to their advantage.

Possessing capital enables some participants and their families to choose when to associate themselves with this group as a member of the Asian community. Hooks (1995) described that to achieve success in a society based on 'white' norms, one has to 'become white'. By this she means performing the symbolic roles and actions associated with being 'white' and sacrificing typically black, or in this instance Asian identifiers. This can be observed when the participants and family members with possession of capital have the privilege of choosing when to associate with their ethnic group, but several participants also describe

their belief that white people are treated with more value by Asian professionals. This form of white privilege is important when considering the impact of current health and social care practices on the minority ethnic population, with this perception being particularly damaging to the identity of patients from minority ethnicities. Salma indicates that she has witnessed this behaviour by health and social care professionals and Farah broadens this out to include supermarket security staff.

Salma describes her understanding of this scenario, but uses the prefix 'they' to denote reference to her mother and the 'Asian community' rather than including herself in receiving discriminatory treatment;

a dominantly English GP, they will actually take more care of them than the Asian ones will which is crazy, yeah?

She also completes this narrative with the rhetorical question 'which is crazy, yeah?' indicating her expectation would be an ethnic loyalty towards other Asians and her presumption that I would expect the same.

Farah describes the inequity between the way Asians treat the white population compared to white treatment of Asians. Her opinion is linked to the example of supermarket security staff, echoing the first theme of generalisability of racist encounters across populations;

you know I've seen Asian people they are really good with the white people they go out of their way to put them right or say 'here', I don't know about the younger generation but it's we always say 'don't do that' you know, be nice, and elder people, whoever it is, be respectful

Here Farah describes her experience, which is rooted in her role as a parent. Her identification of generational difference echoes her understanding of racism as being perpetrated by younger people, but her point is clear in identifying that in her experience, Asian people are good to white people. She then offers a comparison to this;

Tesco's got Asian people, security guard, and the, it's, he'll be more nicer, nice to white people that you know, their own thing, but with the white people they are, they are really nasty to the Asian.

Here Farah claims that the Asian security guard treats white people more favourably than Asians, again making a similar inference to Salma by implying that this is surprising; 'their own thing' associates the security guard and customers by their ethnic similarity, indicating an expectation of ethnic loyalty. Farah continues to describe the treatment of Asians by white people as 'really nasty'. The placement of this sentence immediately following the reference to treatment by Asians in positions of privilege (for example the symbolic capital of power associated with the role of a security guard) indicates Farah connecting these ideas.

Guneratnam (2003) raises the issue of conflating the importance of ethnicity as a characteristic, particularly in research as presumptions of homogeneity influence analysis and results, however, as identity formation is social, the constructed importance of ethnic homogeneity within society has an impact on how others perceive this group, but also upon member's expectations of themselves. Hall (2013) understands this construction as developing a shared system of representation, with Jenkins (2014) and Goffman (1958) both describing ethnicity as a primary identifier. This explains Salma and Farah's expectations of privileging ethnicity over other demographics. The doctor and security guard in the participant's scenarios have prioritised other relationships based on their desired outcomes and idealised identities, which Hooks (1995) would describe as becoming 'white', this therefore means prioritising other associations, such as white people or socio-economic capital.

Despite their expectations of others to prioritise ethnicity, Farah and Salma are in the privileged position, through possession of socio-economic capital, to choose when they associate themselves with 'the community' as described previously. These two women have both physically and psychologically distanced themselves from association, which is indicated by their fluctuating use of the prefix 'they' to denote reference to a group they are not included in. Mohammed is also able to use his privilege to psychologically

disassociate himself from the community he describes, despite living on the same street as his mother, who he includes in the 'Asian community'. Mohammed is able to make this psychological disconnection despite his close physical proximity to the community because of the privilege related to his gender. As a younger male, Mohammed has accessed education in England, can speak fluent English and is able to work, socialise and travel outside of the community more freely. His reference to the 'Asian community' as gossiping about each other is a gendered and age-related assumption that refers to his perceptions of the older women with whom his mother associates.

This division between those who have the capital and privilege to enable a separation from the community means that those with this advantage are able to access what is perceived to be a higher quality service, usually reserved for white people, whereas those without the privileges associated with capital are disadvantaged. The participants most affected by intersectional oppression did not indicate that they understood the importance of ethnicity, socio-economic status or possession of capital in affecting the quality of the services provided locally. Although Safina and Rehana acknowledged that their treatment was racialised, with Rehana identifying poor treatment as a result of racist professionals, and Safina rationalising her positive experience as a result of her language skills, these treatments did not take place at services within the 'Asian community'. This indicates that although they could identify the importance of ethnicity in affecting their treatment outside of the community, they did not generalise this to their experiences with local services within the community, for example their GP. Only Reema appeared aware of this inequality, indicating her belief in a hierarchy between white women and Asian women;

white women are up here *lifts hand high*, Asian women here *lowers hand*, we want equality

Here Reema is referencing the comparable lack of services available in the Asian community to those available outside. From analysis of the interviews we can identify that those participants with privilege can identify the inequality and use their privilege to secure good quality services for themselves, whereas the women without these privileges, although aware of the potential for racism from services based outside the community, are

not aware of the poorer quality services they are receiving from within their safe space. Interestingly, Reema does understand the unequal distribution in quality of provision but continues to attend services based in the community as a result of her focus on social justice, rather than assuming an individualist perspective.

8.5 Complex 'in-group' relationships

It is evident from analysis of the transcripts that the participants' experiences are diverse, and despite their similar age, ethnicity and gender, the women's different socio-economic status has a significant impact on their experiences. It is also evident that their beliefs about each other can be challenged. As discussed in chapter two, the implementation of multi-culturalist strategies was based on the advice of 'community leaders', recruited from the Asian communities to represent the population and advocate for their needs. The underlying presumption here that either the 'community leaders' understood the needs of a 'homogenous' community, or that the community was presumed to be homogenous based on their ethnicity (McGhee 2005). Recruiting spokespeople is not unique to government initiatives and research criteria can exclude those without English language skills (Elbourne and le May 2015, Livingston et al. 2002), a form of cultural capital we can now understand as connected to socio-economic privilege. This means that research conducted about services with minority groups is often only representative of those privileged with the capital to access such services to start with.

There are several instances during the interviews, where the privileged participants make assumptions about those experiencing substantial intersectional oppression. These assumptions are then contested by the narratives of the less privileged participants, revealing the diversity of the women's lived experiences and beliefs about their peers. The implications of this are wide reaching, particularly given the link between English language skills and socio-economic status. Participants with socio-economic privilege appeared to experience difficulty empathising with those that lack privilege and capital, and therefore are unrepresentative of their needs. Guneratnam's (2003) work identifies that this is one of the challenges for work with minority ethnic groups, as it represents a conflation of the importance of ethnicity, and an assumption of the homogeneity of a population based on

this one constructed demographic, rather than understanding the diversity and complexity of the interaction between individual and group identities.

Throughout the interviews there are three occasions where more privileged participants and their family members make judgements about those from the 'Asian community' who experience disadvantage which are then contradicted by those in disadvantaged positions;

1. Reluctance to complain
2. Unwillingness to pay for the luncheon club
3. Refusal to travel to services

8.5.1 Reluctance to complain

As previously discussed, both Farah and Salma make the generalisation that the 'Asian community' are reluctant to complain about poor treatment and as a result, continue to receive such a standard of care. Their assertions imply that the blame lies with those who fail to report the poor treatment and in Farah's case, extend this characteristic from interactions with health and social care services, to interactions with schools and other services.

This generalised assumption is contradicted by Reema's narrative account of her poor experience with her doctor. As an English speaker, Reema does possess some privileges not afforded to other participants, but her use of the prefix 'we' indicates that she aligns herself with the other participants and luncheon club members. When confronted with a perceived injustice perpetrated by her doctor, she is keen to complain and is only prevented from doing so by her daughter;

in my mind I have very big issue, but my daughter she say leave it

Interestingly Reema's daughter is a younger, employed, English speaking woman, possessing the privileges afforded to youth and the social capital that comes with employment. From an intersectional position, her privileges and capital mean she is likely to experience less oppression, but still encourages her mother not to complain. These

contradicting narratives are presented not to try and identify which assumption is 'true', but to highlight the challenges present when expecting people to speak on behalf of others without understanding their circumstances, purely because of a shared ethnic background, an expectation frequently made of minority ethnic groups. Here Reema, a woman with limited capital and experiencing significant intersectional oppression is prepared and willing to complain and is only prevented from doing so by someone in a more privileged position, contradicting the assumptions of other participants.

8.5.2 Unwillingness to pay for the luncheon club

Farah makes a similar assumption when describing the recent concerns about the luncheon club closing. It is her belief that if all the members paid 'you know, one pound two pound' then the club would continue to run, however she then states that;

But some of them are very, very tight! Even though it's just a pound or two pound they don't wanna part with those

Here Farah explicitly refers to the women as 'tight' which indicates a substantial strength of feeling for Farah, as her usual linguistic style is to avoid any explicit negative statements about groups that she is associated with as she prefers to present such information in a more positive light. The choice of language here demonstrates Farah's confidence in the accuracy of her assumption and her strength of opinion, which could be as a result of her desire for the luncheon club to remain open.

Conversely, Rehana, the participant experiencing arguably the most intersectional disadvantage, directly challenges Farah's perspective in her narrative account of the same concerns regarding the future of the club. Rehana repeatedly refers to her low income throughout her interview, and describes the cost of travelling on public transport to appointments as her 'main concern', however despite this, she still asserts that she is prepared to pay to access the luncheon club;

they don't mind paying, a pound, pound fifty to get transport, they don't mind paying

This financial commitment to the club is significant for Rehana, as she has very limited funds, with her entire income dependent on benefits, indicating her prioritising of the club's success and acknowledgment of its importance for her and her peers. This is confirmed by Rehana's next sentence, interpreted by Ali, that describes 'a lot of women' would be prepared to make a financial contribution to ensure the club's security. Rehana's belief that many of her peers would contribute directly contrasts with Farah's expectations of the women, some of whom she believes are 'tight'.

8.5.3 Refusal to travel for services

Contradictions in relation to the willingness of Asian community members to travel outside of the community are another indicator of the dangers of accepting assumptions as 'truths'. Some participants believed such travel would not be an option, whilst others were making significant journeys on public transport. Again, the point of including these contradictions is not an attempt to ascertain which narrative is 'true' but rather to demonstrate the difficulties in searching for 'truths', particularly when those with privilege are expected to speak on behalf of those without, despite not understanding their circumstances. In this instance, both the privileged participants and those experiencing significant intersectional oppression relate this reluctance to travel to a lack of English language skills, however this lack of cultural capital is associated with socio-economic status, meaning that the participants' assumptions can be interpreted as suggesting that socio-economic status inhibits access to services outside the community.

8.6 Implications

The importance of these assumptions cannot be underestimated, frequently in research the importance of one characteristic is conflated, and the opinions of those in possession of such characteristics (in this case older Pakistani women) are expected to be successfully generalised across a population. The importance of recognising intersectional oppression and disadvantage is highlighted in the examples, where those in positions of relative

privilege made assumptions about those experiencing substantial intersectional oppression. These assumptions were then challenged by the narratives of those women with lived experience of disadvantage, highlighting the problems of representation faced by both services and researchers when attempting to capture experiences of a diverse and heterogenous group. These problems are increased by the tendency to conflate the importance of particular characteristics to the detriment of others.

9. Practice Implications and Conclusion

9.1 Introduction

This research project set out to explore the experiences of Pakistani older women and the relationship between their experiences of and under-representation in health and social care services. A wide spectrum of unique narratives contributed and despite their variety, four consistent themes emerged. This chapter addresses and extends the original objectives, acknowledging the importance of intersectionality and the inadequacy of an over-emphasis on race or ethnicity to address the challenge of under-representation.

The previous three chapters have explored the data; in chapter six the focus was on the individual participants through the use of dialogic performance analysis to demonstrate how identity is constructed and presented through use of language and performance. Following this, chapter seven explored the connections and shared experiences of the women using thematic analysis to develop four interconnected themes, three of these themes were presented in chapter seven. The final theme; intersectionality, was discussed in chapter eight, where the importance of recognising diversity of experiences was explicated. This final chapter collates information from the three previous chapters, along with existing literature from chapter three and elsewhere, demonstrating how the findings extend existing knowledge and can be applied to the practice context. The chapter is divided into six sub-sections. Rather than reflecting the four themes from the research, or the ten themes from the literature review, these six parts represent a chronological approach, starting with the current health and social care system, outlining the impact it has on those from disadvantaged groups. The intersectional nature of key challenges with this system are then discussed, before considering the potential for change, and the significant shift required to facilitate this.

9.2 Current Response

The current response to under-representation of minority ethnic patients in health and social care services stems from duties under The Equality Act (2010) to ensure that those with protected characteristics (including race and religion) are not discriminated against.

The Act also outlines specific responsibilities for public bodies (including the NHS and local authorities) to actively work to eliminate discrimination, harassment and victimisation. In order to meet these requirements, the policy and research focus has been on developing a culturally competent workforce, with almost half of the literature review papers discussing this requirement. Despite being high on the practice agenda, cultural competence was not mentioned by participants throughout the whole research project explicitly, nor was this identified during analysis of the transcripts. As Guneratnam (2008) describes; the emphasis on and preference of practitioners for 'fact-file' cultural knowledge training may be preventing good quality relationship-based care being provided and rather, encouraging essentialist understandings of ethnicity.

Participants and their chosen interpreters offered several practical suggestions for improving service provision throughout the interviews, these included more local advertisement and the GP to be used as a source of knowledge and information, alongside providing more local services and support. Evidence from the analysis indicates that the reasons for local provisions being preferred are complex but relate to reluctance to travel due to the challenges this entails; predominantly issues of finances, language, low confidence and feeling unsafe travelling outside of the local community. Although providing the much-requested local provisions would ease these feelings of apprehension for participants, it would not address the underlying reason for their fears, which are reflections of broader societal issues. In addition, several participants raised concerns about their GP, for example both Muna and Sayida felt their health concerns were not taken seriously, and Yasmin experienced painful treatment, felt to be unnecessary by her and her son. Farah and Salma both had the privilege of experiencing good quality care and made racialised assumptions about the reason for this in comparison to the care sought within the Asian community.

Although participants explicitly suggested advertising support services in the local community, such as in GP surgeries and the community centre, a recommendation also made by Petch (2003), contradicting evidence from Manthorpe et al. (2009) and Alam et al. (2005) found that translated material alone was not sufficient, and that without contextual understanding, patients were not able to utilise the information. Alam and colleagues specifically identified that participants would prefer a conversation over written

material. Analysis of the participant's narratives in the current study indicate that despite suggesting such a strategy, their experiences, and the understanding of services and professionals developed as a response, would be likely to prevent people from accessing information in this way.

The narratives included in this thesis indicate that the current response to under-representation and discrimination in access to health and social care services has not been adequately addressed despite Equality Act (2010) or Care Act (2014) duties. Focus on practical steps and training a largescale culturally competent workforce have concentrated on knowledge rather than reflexive practice and relationship building (Guneratnam 2009, Willis et al. 2016a) and the experiences of those living with multiple disadvantages present a damning picture.

9.3 Racism

Racism is acknowledged either explicitly or implicitly by all participants and dialogic performance analysis of the narratives enabled an exploration of how these experiences of racism impacted on the identity of the participants. Comparing the narratives of racist incidents of Rehana, who lived with multiple intersectional disadvantages encounters, with Farah, who, although experiencing disadvantage also possessed substantial capital and privilege, we can see that a lack of privilege and capital appears to increase the impact of racism on identity.

Contributing to the complexity of this interaction is the proportion of interactions the participant engages in outside of the Asian community that had racist content, and the position of the person this exchange is with. For example, Rehana very rarely travelled outside of the Asian community she lived in and most of these occasions were to meet with a health professional, several of these interactions with health professionals contained what she perceived as racism, and the perpetrator was often a professional, with considerably more capital and privilege than her. In comparison Farah lived in a 'white community' and travelled regularly and independently, frequently interacting with people with more and less privilege and capital than her. Therefore, although Farah describes

racist incidents, these are not as significant a proportion of her overall interactions, and often come from those who she perceives as possessing less capital than her.

Dialogic performance analysis (Riessman 2008) allows such conclusions to be drawn as it focusses on the linguistic and performative aspects of narratives, therefore when both participants describe their experiences we can explore their performance of self. As the researcher, having a contextual knowledge of the participants from the time spent at the community centre, I am able to compare the performance described in narratives of racist encounters with the participant's performance at the centre, in a safe and familiar environment.

Although a small sample, there is evidence to suggest that those experiencing more extreme disadvantage are more vulnerable to internalising racist experiences to impact on identity. Jenkins (2014) describes identity as social, and developing in interaction with others in a dialectic, therefore we can see from Rehana's subdued response to racism from professionals, that her identity in these incidents has been shaped by the racist behaviour towards her. Hall (2013) would suggest that repeated exposure to racism from health professionals alongside the local and national context that places ethnicity as a primary indicator, facilitates the development of a system of representation, whereby health professionals as a group are deemed to be prejudiced and discriminatory. This system then has significant implications for those in disadvantaged positions as they have little or no capital to either counter these negative perspectives or use the unequal system to their advantage.

Evidence from the analysis suggests that participants were aware of the unequal experience of health and social care. Rehana perceived the professionals she encountered as racist, whereas Farah and Salma were able to compare the services provided within the Asian community with those they had experienced in 'white areas', believing these to be of a higher quality, Reema also understood this comparison but chose to advocate for more comprehensive local provision. In addition, possession of capital enabled strategic use of this unequal provision, for example using economic capital to relocate to a GP practice in a white area or using cultural capital to negotiate earlier appointment times.

Presenting a two-category contrast based on ethnic disadvantage doesn't allow for the complex matrix of individually experienced disadvantage and Crenshaw (1989) warns against any attempt to create a hierarchy of disadvantage. For example, Yasmin possessed very little capital individually, but her son's role of protector enabled the use of his capital as a professional English-speaking male in order to identify and challenge poor treatment.

The literature review data offers support for this unequal system, with Burr (2002) and Merrell et al. (2005) describing the discriminatory cultural stereotypes professionals hold as impacting on diagnosis and care pathway choices. Manthorpe et al. (2009) found GPs were unable to relate to their minority ethnic patients, with Merrell et al. (2005) concluding that these professionals were missing opportunities to disseminate information about available support. Alam et al. (2005) and Forbat (2004) lend support to Hall's theory of representation by identifying that minority ethnic participants' expectations of their treatment were affected by experiences of everyday racism, leading them to expect poor treatment from health and social care professionals, akin to that described by the participants of the current study. Further support for the development of such a system of representation comes from Beattie et al. (2005) who indicates that professionals working in specialist minority ethnic services also hold these expectations of unequal provision, believing mainstream services to be racist. Forbat (2004) extends this lens of discrimination to assert that the current system is not only institutionally racist, but that both policy and practice are racially abusive.

The focus in the literature is on race and ethnicity, with services described as racialised, however Guneratnam (2008), in line with an intersectional approach, considers that such claims fail to consider individual needs. She asserts that the focus on ethnicity has led to requirements for 'cultural competence', which is diluted via training on cultural knowledge resulting in essentialist understandings of ethnic difference and preventing individualised relationship-based support being provided. From the diversity of experiences described in the current study, it is evident that ethnicity is not the sole primary indicator defining experience. All participants shared an ethnic identity, but their experiences differed based on distribution of capital and privilege, for example the experiences of Farah and Rehana were not similar, despite their shared ethnicity, age and gender.

Socio-economic privilege and associated capital had a significant influence on the experience of participants, impacting on factors such as ease of and ability to travel, awareness of services and language skills. Language skills were associated with intelligence by the participants, with Rehana describing professional's belief that she was stupid, and Farah describing those without English language as 'knowing nothing' on several occasions. Interlinked with intelligence, language was also associated with confidence, both to travel and to speak to professionals independently.

Since 2010, health and social care services in England, particularly local authority managed provisions, have been subject to substantial austerity measures. This has led to the closure of some services and the reduction of others (Hastings et al. 2015). At the time the data was collected for this study, the transport service that many of the participants relied on to bring them to the community centre had recently been stopped. This was an issue for several of the women, and particularly affected those experiencing multiple disadvantages. For example, Farah, who possessed substantial privilege drove to the group, therefore was not affected and Yasmin continued to be driven to the centre by her son. The women who were not able to drive, or utilise familial privilege – for example Rehana, Tasleem and Muna now had to walk to the centre.

Although the budget restrictions, both locally and nationally were cross-cutting, there is evidence from the literature and from the current research, that the impact is felt intersectionally. Beattie et al. (2005), prior to austerity measures, identified transport cuts were a concern across participants of multiple ethnicities, however when researching practitioners working with minority ethnic people, Lipman (2015) found them to believe they experienced more cuts to provisions. This is supported by Manthorpe et al. (2009), who concluded that the impact of austerity measures was greater for those from minority ethnicities. The key term in the Manthorpe et al. paper is 'impact'; although the budget cuts that lead to the decision to stop transport funding may be cross-cutting, the 'impact' is felt intersectionally. For example, although transport in predominantly white areas of the town may also have been cut, the same fears of travelling on public transport due to lack of language skills and confidence, associated with education and economic capital are not present.

9.4 Language

Language skills were seen as fundamental to the provision of a good service by the participants, with Sayida relating the success of her hospital treatment to her ability to communicate in English and Salma claiming that her mother Muna and her peers were not allocated GP appointments fairly because of their lack of language skills. Farah associated ability to communicate in English with intelligence, a theme also asserted by Rehana, who encountered this attitude from hospital interpreters during appointments. Connected to language skills is the issue of interpreter use and confidentiality, both of which were also raised as problematic for participants. As described above, and within the previous chapter, English language possession is not an isolated skill that is accessible equally to all individuals who have a different first language, and therefore the absence of this skill has an intersectional impact, as enshrined in Rehana's experiences of discriminatory treatment.

Merrell et al. (2006) identified that possession of English language skills within the Asian population is gendered and age related, therefore understanding the participants of this study as less likely to enjoy this privilege. In addition, the findings of the current study indicate that socio-economic status and capital also contribute, with those in positions of privilege being more likely to have acquired this skill, and those with most privilege being able to practice their English in daily interaction due to their residence in 'white areas'. The existing literature presents several detrimental effects of not being able to communicate in English, which, taking the information above, are more likely to affect those in the most disadvantaged positions.

Merrell et al. (2006), Manthorpe et al. (2012) and Greenwood et al. (2016) all found issues with reliance on interpreters, indicating that this led to delays in appointments and accessing services, making processes more complicated and exacerbating existing difficulties in navigating the health and social care system. The research by Manthorpe and colleagues also highlighted the use of sweeping policies that banned family and friends from interpreting during appointments. Pound and Greenwood (2016) and Willis et al. (2016a) utilised data from professionals that suggested they also found lack of shared language detrimental to their relationship with patients and service users. Professionals interviewed by Willis and colleagues believed they were unable to negotiate with service

users or offer the support and advice they would usually provide, whereas participants in Pound and Greenwood's research struggled to build a relationship across the language barrier.

As described above, the practical implications identified by the existing research have an intersectional impact, with those experiencing the most disadvantage feeling the most impact. Rehana experienced substantial discrimination from interpreters, and also felt discriminated against by nurses during her in-patient stay because of her inability to communicate using a shared language. Her lack of support from informal sources also contributed to this, compared with Yasmin, who also lacked shared language, but was accompanied by her son, whose position of relative privilege ensured her protection and Safina, who was able to communicate in English during her hospital stay. Ali encapsulates this inequity in her powerful statement 'she's got backup, innit' in reference to the difference between Rehanna and her mother Tasleem's treatment.

Compounding the practical implications of a lack of shared language is the impact on individual and group identity. Participants of this study connect discriminatory treatment to racism rather than the complex matrix intersectional oppression that the data reveals. Guneratnam (2003) warns that an over-emphasis on race as a defining characteristic will lead to the prioritising of this demographic over other explanations for disadvantage and this is supported by the current findings. Due to its elevation as a primary indicator, particularly in the local context of racial division, the narratives of participants in this study indicate that this over-emphasis on ethnicity does lead them to attribute discrimination to this characteristic. For the most disadvantaged this is then internalised as described above but also contributes to the development of a system of representation that defines health and social care professionals and systems as discriminatory based on ethnic division, overlooking socio-economic and gender-based aspects.

Sweeping responses to equality legislation that deny the use of informal interpreters (described in chapter five) further disadvantage those that could otherwise be supported by family or friends. However, those experiencing the most oppression are individuals without the option of informal care networks. Despite this, some of the participants do benefit from the capital of their family, for example Yasmin, Tasleem and Muna are supported by their children, whose age and language privileges enable them to advocate

for their mothers. Preventing the adoption of this form of support raises concerns about confidentiality when depending on formal interpreters in addition to the practical challenges described above, but also fails to address the issue of discriminatory treatment experienced by those without the option of informal support. Focussing debate on whether informal interpreting should be allowed ignores the most disadvantaged, who are discriminated against because they have no option but to use the formal systems provided. These systems include the professional interpreters that are included in the system of representation that defines them as discriminatory and oppressive.

9.5 Non-complaint

Much as systems of representation can explain the perception of health and social care professionals by the participants, the reverse can also be evidenced. As described across the analysis chapters, there was an assumption by the more privileged family interpreters that the reason their mothers, and the Asian community more generally, received poor care from services within their community was because of the expectation that they would not complain. This assumption was echoed in Greenwood et al.'s 2016 paper that described concerns relating to the practice of ethnic matching care workers with service users. Here the participants explained that these care workers may exploit service users because of the shared understanding that they would not complain about poor treatment, leaving them vulnerable to abuse. Amongst participants in the current study, Salma and Farah, individuals with substantial capital and privilege indicated that the Asian community was at fault for not complaining, Yasmin's son Mohammed, who also possessed capital and privilege, performed to this group norm, by using his influence to change GP practices, rather than confront poor practice. Reema also conformed, despite her strong sense of social justice, and recognition that her treatment was discriminatory, she was convinced not to complain by her daughter. The strength of this attribute indicates its embeddedness as part of a representational system or aspect of group identity that characterises behaviour when interacting with professional services.

There are broad implications of this expectation, particularly in light of the experiences of racism and the challenges associated with lack of shared language described above, which indicate that the participants experienced multiple interactions worthy of complaint.

Discriminatory behaviour left unchallenged is internalised to have significant impact on the identity of the most disadvantaged, but also contributes to the representational system of minority ethnicities held by professionals. This shared understanding that complaints will be withheld is dangerous particularly in times of austerity where services are reduced and operate tight budgets. In her limited narrative, Sayida described her privately funded acupuncture treatment as a result of the doctor's ambiguous response to her request for this treatment via the NHS. This example demonstrates how referrals can be avoided when patients are uninformed about their rights, and do not feel able to challenge professionals. In addition, the research undertaken by Manthorpe et al. (2009) and Lipman (2015) reminds us that specific services for minority ethnic individuals are more likely to experience austerity measures, and minority ethnic service users are more likely to feel the impact of cuts to mainstream services.

It is important then, to consider why this perception of 'non-complaint' persists, through the lens of intersectional disadvantage and power. Professionals involved in health and social care, including consultants and GPs are bestowed with substantial capital and privilege, they also hold the knowledge and power necessary to provide diagnoses, support and advice to those with health care needs. They are also most commonly able bodied (Ryan et al. 2015), white, middle aged (NHS Digital 2018 [online]) males (NHS Employers 2018 [online]). This means that they are held in high regard and are respected by both patients and other health and care employees. The experiences of those living with multiple disadvantages in interaction with high-status health care professionals, as encapsulated earlier in the chapter, is characterised by complex discrimination, perceived as racism and challenges due to lack of shared language. These experiences contribute to expanding the already existing difference in capital and privilege between the professionals and patients, therefore exacerbating the power differential and making it even more challenging to express negative opinions about such high-status authorities.

Contributing to this dynamic is the explicit assertion by comparably privileged members of the Asian community such as Farah and Salma, that the community themselves are to blame for the discriminatory treatment they receive. The next two subsections draw on the theories outlined in chapter four to explore the potential routes to address the discriminatory and unequal system exposed by the narratives of participants.

9.6 Capital and privilege as a protective factor

Privilege, including the possession of capital can be described as a protective factor which cushions the impact of discriminatory treatment on the identity of disadvantaged individuals. We can also understand this as intersectional, with those assuming the most disadvantaged positions being most exposed to the impact of discrimination and oppression. The current focus of cultural competence training as a fact-file, knowledge acquisition activity (Gunaratnam 2008, Willis et al. 2016a) is the preferred approach of practitioners, but this is inadequate and leads to essentialist understandings of group identity that fail to appreciate the complex intersectional nature of disadvantage.

Houston (2002) encourages social work professionals to reflect on their own capital and experience with different fields (education, health, social care) in order to better understand their own value base and prejudices. Willis et al. (2016a) and Larkin (2018) support this notion, proposing a reflexive approach to working with diverse service user groups and offering the concept of cultural affordance to aid understanding of the context dependent nature of culture and community. Furthermore, Houston offers a four-point reflective process to support social work practitioners to relate to individuals living with disadvantage (described in chapter four) culminating in the suggestion that maximising and developing existing capital is important in redressing the balance between professionals and service users. This increase in capital is then thought to empower individuals experiencing disadvantage to challenge inequality and claim their right to support.

In social work practice, this concept is not new, with rights movements dating back several decades and achieving successes such as the now terminated Independent Living Fund enabling those with physical disabilities to live independently (Glasby and Littlechild 2016). Critical social work developed as a response to neo-liberal policy that moved practice away from relationship-based work alongside service users and towards care management (Healy 2000, Fook 2012). Critical social work theories are diverse but share an understanding that an imbalance in power exists between structures such as government, the NHS and local authorities and those that require the support of these structures. In order to counter this unequal distribution of power, support must come from the communities themselves, alongside independent support, rather than those who represent

power structures. Houston's (2002) proposed response echoes that of critical social work and considers the move to viewing service users as experts by experience as a step towards rebalancing the power disparity between service users and professionals.

The recent refocussing of adult social work to prioritise strengths, as platformed in the Care Act and accompanying guidance indicates an acknowledgement that those requiring support from services possess valuable qualities and skills. More specifically work by Krumer-Nevo and colleagues (2016) to develop a 'poverty aware paradigm' to support and empower those who lack capital is an important step towards recognising the vast inequality in capital distribution. This approach advocates improving the economic capital of those in poverty by providing practical financial support alongside the use of practitioner's cultural and symbolic capital to empower those experiencing disadvantage through direct work. The poverty aware paradigm is underpinned by recognition of the intersectional nature of disadvantage and is focussed on supporting women who are living with very low incomes (Krumer-Nevo and Komem 2015).

The interventions described under the critical social work umbrella correspond with suggestions from Houston (2002) that utilise Bourdieu's (1989) work on capital, however they are confined to the social work profession. The participants in this study had little or no experience of social work or care intervention and all chose to share a narrative of healthcare. Despite the recent advances in social work practice, the health focussed narratives relayed during interviews described incidents where a professional hierarchy was apparent, for example Rehana described an interpreter prioritising their own relationship with a consultant over supporting her, and nurses adapting their behaviour to perform their role more appropriately when in the presence of doctors. Participants and their families also prioritised the status of health professionals, for example Yasmin and Mohammed preferred the psychologist's appointments over the counselling meetings because of the perceived status of the qualified professional. These examples suggest that initiatives to empower and improve the capital of service users, promoting their strengths in order to address the imbalance of power have been unsuccessful. The methods used by participants and their families to adapt to this understanding of health and social care hierarchies, such as lowering expectations and taking a more privileged chaperone, serve to perpetuate the hierarchical nature of power rather than challenging this system.

It is evident therefore that although the distribution of capital and privilege is unequal, and the impact is intersectional, that attempts to redistribute capital have not reached the participants of this study. The next section considers the reasons for this failing.

9.7 Systems of representation

Hall describes systems of representation as responsible for our perceptions of specific groups or concepts (2013). Similar to the development of group identity as proposed by Jenkins (2014), we can see how these develop in interaction with 'others' in a dialectic, simultaneously internalising and externalising. Therefore, in relation to the current study, we can understand how the participants have developed a system of representation to understand health and social care professionals, and conversely, how primary identifiers have contributed to professionals generating a system of representation that encapsulates their understanding of the participants as members of a minority ethnicity.

This explanation can be challenged for its failure to consider intersectional disadvantage, and the importance of this in contributing to participants' experiences, however attributes of the representational system, such as a failure to complain, appear to pervade the intersectional nature of experiences. This can be seen in Mohammed's decision not to address his mother's ill treatment with the GP surgery. These contradictions and complexities can be explained by Hall's use of the term hysteresis, whereby Mohammed's capital does not hold the same value in the health and social care system as it does in his local community, where his performance during the interview indicates his belief that he is held in high regard.

Research by Barn (2008) and Merrell et al. (2005) demonstrate how systems of representation can have significant impact on individuals, describing how stereotypes about Bangladeshi women lead to different care pathways and diagnoses. In addition, Manthorpe et al. (2009) discuss the failure of GPs to relate to their minority ethnic patients, leading to lower referral rates for some services. It is therefore fundamental to address these representational systems, in order for attempts to increase the capital of disadvantaged groups the opportunity to make positive changes.

Hall (2013) proposes three processes to address discriminatory representational systems (described in chapter five). The final suggestion of contesting representation from within is of particular relevance as this includes challenging binary notions of identity and dismantling expectations. For example, Farah's encounter with a racist couple in a car park could be seen the result of a binary system of representation that lead the couple to assume that an older Pakistani woman could not hold this identity alongside having the economic capital to afford an expensive car. Gunaratnam's preference for doubled research parallels this idea, platforming the importance of using representational systems, or primary identifiers within research in order to challenge these concepts rather than reaffirming them.

Previous health and social care research can be seen to reinforce systems of representation that prioritise ethnicity as a binary notion of identity. For example, Elbourne et al. (2015) included the need to speak English as one of the requirements to participate in their research, and Livingstone et al. (2015) excluded 15% of residents in their location-based study due to lack of interpreters. In addition to these explicit exclusions, Yohannes et al. (2008) referred specifically to concepts associated with Christianity when exploring the impact of religion on health. The discriminatory nature of research decisions such as these are problematic, particularly when we consider the intersectional nature of language skills. Analysis of the narratives from this study expose that participants clearly linked possession of English language skills with intelligence and cultural capital rather than economic capital, age, gender and accompanying privileges.

The failure of researchers and policy makers to recognise the importance of intersectionality means that the findings relating to binary notions of ethnicity are not representative of the diversity of experience within this group. Qureshi (1998) described how Bangladeshi older people felt overlooked during consultations in favour of 'community leaders' and more recently Willis et al. (2016b) found that professionals recognised language barriers a problem when attempting to collect feedback about services. This indicates that if feedback cannot be sought, then services will not be shaped around the needs of those without English language skills. From the current research, we can identify this group as those experiencing the most disadvantage, and therefore in most need of supportive and appropriate provisions. An example of this failure to align services with

needs is explored by Mold et al. (2005) in their review of residential settings, where researchers concluded that a 'one size fits all' binary understanding of cultural needs contributed to stress felt by minority ethnic residents.

9.8 Limitations

Despite every effort made to ensure this thesis was well considered, planned and conducted with a clear philosophical underpinning, there are always limitations that are unique to the circumstances of the study. In this section I will outline what I believe to be the two main challenges to this study.

9.8.1 Participation.

Gunaratnam (2008) advocates the use of doubled research, using ethnic binaries in order to challenge their existence. Similarly, Hall encourages us to contest discriminatory systems of representation by exposing the complexity of individuals defined within their narrow and essentialised categories. One way social work practice has sought to conduct such research is through the concept of participation. Cresswell (2003) summarises this as research that is focussed on facilitating change, takes a critical perspective on power distribution within society, is emancipatory in addressing such power imbalances and involves working 'with' rather than 'on' participants. Often this takes the form of including the subjects of the research in all stages of the study, including the planning and establishing of aims and objectives.

Although criticised as tokenistic by academic-activists such as Beresford (2000), participatory research fits with Hall and Gunaratnam's (2008) proposals for dismantling discrimination based on binary assumptions by enabling a redistribution of capital between participant and researcher. In addition, this form of research can challenge the systems of representation developed that those facing discrimination hold about professionals. These systems that may have developed as a result of systematic oppressive treatment from practitioners can be destabilised by working in partnership to reach shared goals.

The current project includes some attributes of participatory research, as defined by Cresswell (2003), however participants were not involved in the design of the study, nor

were they consulted on the aims. This is a limitation as it means that by failing to include the women in the planning stages, I missed an opportunity to address the imbalance of power between us, instead contributing to the inequality of capital, with myself as the researcher possessing the cultural capital rather than sharing this.

Although this is a significant limitation to the study, additional steps were taken to address the inequality of power, privilege and to help dismantle the representational systems I am part of. These are described in the next section.

9.8.2 Me, my capital, privilege and performance of self

All qualitative methods of data collection and analysis require a reflection on our own position, and the impact we have on the research we undertake (McLaughlin 2012). I am a white, middle class (by profession, not birth), able bodied woman in my thirties. My education and employment mean that I have substantial privilege and associated capital. Although 'race of interviewer' research presents a complex picture (Gunaratnam 2008) the impact of researcher ethnicity is more evident when investigating subjects that are constructed as 'racialised'. This means that my primary identifiers, and the systems of representation associated with them, have an impact on the participant's responses to me. In this research, the impact is compounded by the requirement to interpret via a third party. Furthermore, my life experiences alongside my research interests will influence how I interpret what is shared, for example my struggle to reconcile my working-class background with my middle-class profession mean that my sensitivity to class difference is heightened. Riesmman (2008) acknowledges this and asserts that analysis must remain tied to the evidence from transcripts (discussed in chapter five).

In an attempt to reduce the unequal power distribution between myself and participants, I was conscious of my performance of self. Many of the qualities I perceive to be required of a 'good narrative researcher' are also qualities found in social work practitioners, for example empathy, sensitivity, honesty and integrity are entrenched social work values. This compatibility means that much of my performance during the interviews was sincere however I also made conscious choices in order to facilitate good relationships with participants and their families, Goffman (1963) refers to these conscious decisions as

cynical aspects of performance. Examples include my choice of clothing; on days when I attended the community centre I was conscious to cover my legs and not wear items that were 'revealing'. I viewed this as respectful and an attempt to ensure that my performance was well received by the audience, facilitating a relationship between myself and the members. In addition, I was aware of my usual fast paced speech, and made a conscious attempt to slow my speech down and speak more clearly, in order for those members whose English was less advanced to understand me. Simultaneously I was mindful not to present as patronising or make stereotypical assumptions about intelligence.

The local context is important when considering both performance and researcher impact. As the analysis revealed, although discrimination was often expected from professionals, when racism was encountered in the community, it was associated with young, white, working class males. This association is evidence of the lasting impact of the unrest in the town between the Asian and white communities. Here we see the importance of intersectional understanding in all aspects of the research; using only ethnicity, my whiteness, a shared characteristic with the perceived instigators of the unrest, would be detrimental to relationship building. Including gender creates a commonality between myself and the participants, and a difference between myself and the stereotypical car park racist.

It is therefore, inevitable that the narratives shared with me, may not have been shared with a male researcher, or one that bore indicators of a local working-class background. In addition, such a researcher may have analysed the transcripts differently and developed alternative themes. Dialogic performance analysis has clear expectations in relation to validity, as described in chapter five, in order to ensure research outcomes are justified. Rather than seeking to establish fixed, generalisable outcomes, this thesis hoped to explore the diverse experiences of a small group of women and offer an explanation for the different encounters that could be related to existing theories. It is this relationship to existing theory that enables more general conclusions to be drawn.

9.9 Conclusions

Fundamental to the findings of this research are the participant's experiences of intersectional oppression. The most disadvantaged experienced poor treatment and felt a

lack of power to challenge. This disempowerment was perpetuated by those with comparable privilege who blamed them for their inability to challenge and therefore improve their own circumstances. This consistent poor treatment, experienced as racism lead to a detrimental impact on identity, demonstrated by low confidence and subdued performance of self in interaction with professionals. In combination this has led to a withdrawal from support services, especially those located outside of a personally defined safe space, namely the Asian community. This is exacerbated by the local context of historic unrest and recent national and international right-wing responses to extremism and terror threats.

Attempts to address the unequal and discriminatory system have been inadequate as research and policy often exclude those experiencing the most disadvantage because of a lack of shared language and reluctance to engage with services due to prior experiences of discrimination. Insufficient and unsuitable responses are then based on the testimony of those with comparable privilege, deemed to fit the same binary definition, focussed on the primary identifier of ethnicity.

Binary systems of representation have been developed and are wide reaching, therefore localised or profession-specific attempts to address discrimination by increasing the capital of those experiencing disadvantage, for example within the social work profession have had limited success as they have not challenged existing representational systems sufficiently. These attempts can be seen as outliers to a group identity or representational system that has developed an identity external to its members.

These binary representational systems require society-wide challenge by the prioritising of doubled research and intersectional understandings of discrimination and disadvantage. The focus must progress away from inadequate cultural competence-based training that provides fact-file knowledge and therefore encourages essentialist understandings of ethnic binaries. Instead there must be a joint focus which prioritises reflective practice and challenging stereotypes that elevate the importance of race and ethnicity over more complex intersectional understandings of individual experiences and needs.

In addition, there needs to be a recognition that the development of representational systems is dialectic, and that individuals experiencing disadvantage have also developed

expectations to predict the behaviour of professionals. Where experiences have been predominantly negative, based on racist encounters or discriminatory treatment, this, alongside contextual factors, contributes to a presumption of poor care and treatment. Where available, the participants of this study utilised their own capital to counter these expectations, for example moving to a different GP surgery or taking a more privileged family member for support. These individualised attempts represent an acceptance of this discrimination however, rather than a collective response.

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Appendix I: Literature Review Extraction Table

ID no.	Authors	Subject group	Participant details	Method	Summary/Findings	Quality	Relevance
1	Larkin et al. 2018	Learning disability	32 ME adults with mild/ mod LD	3 x interview per participant template analysis	Cultural commitments are context dependent Continuity of good relationships as importance 'cultural affordance' model as helpful for profs Unhelpful to make assumptions based on discrete categories of ethnicity Aspects of good quality care are cross-cultural	Strong Inc. Method Quotes limitations	Medium Different SU group Generalisable themes
2	Malik et al. 2017	Learning disability	10 British South Asian women with LD	Semi-structured interviews IPA	Services can help facilitate/develop complex cultural identities Intersectional oppression recognised as affecting women	Strong Method Quotes Limitations	Strong Different SU group Same ME group Similar themes
3	Willis et al 2016	Practitioners	39 social care practitioners	In-depth qualitative interviews Thematic analysis	Diversity is a challenge to professional competence and effective care provision Language barrier and cultural differences are factors Solutions – asking right questions, right kind of training, being even more person centred	Strong Method Quotes Limitations	Medium Worker perspectives Different ME groups Generalisable outcomes
64	Pound et al. 2016	Carers and stroke patients	50 carers 5 different ME groups	Semi-structured interviews Thematic analysis	Experiences are shared across ethnic groups but language barrier/cultural diffs exacerbated pressure/stress 1. Communicating w system – shared 2. Impact/time – shared 3. Communication/rapport – lang as challenge 4. Trust/safety – shared 5. Humane/humanly sensitive care – shared	Strong Method Quotes Limitations	Low Mixed ME groups Carers of different SU group Generalisable theme
5	Lipman 2015	Practitioners	12 policy and	Review of policy	BME services – greater funding cuts than mainstream Mainstream services reducing specific provisions	Low	Medium

			provider org reps Mixed ME	12 semi- structured interviews	BME SU choices are limited =need to contribute to data collection in order to counter challenge and assess equality of access	No method No quotes	Generalisable themes Mixed EM pracs
6	Greenw ood et al. 2016	Carers	41 stroke carers 5 ME groups	7 focus groups Thematic analysis	Hospital – home gap – shared Balancing effort in accessing services with needs – same Poor/unsuitable services – same Carers as best person to care – BME related to culture/duty Culture as part of caring – Lang/communication as important *IDs carers from same ME will take advantage of Sus due to lack of complaint	Low Excluded non-English Speaking Power in focus groups	Medium Mixed ME carers Generalisable findings
7	Willis et al. 2016	Carers and adults	82 S.Asian and white carers and Sus	Semi- structured qualitative interviews Thematic analysis	Ps were more likely to rate satisfaction positively even when experience was good and bad No ethnic differences Need to have space for narrative responses Culture and language as a challenge for feedback to services	Strong Method Quotes	Strong
8	Mantho rpe et al. 2012	Carers/ adults	82 carers, practitione rs and Sus in 4 rural areas	Semi- structured interviews Thematic analysis	Poor access to interpreters and sweeping policies of ‘no relatives interpreting’ = longer waiting times Training and skills development was limited Isolation/loneliness as an issue identified by all	Strong Quotes Method	Medium Similar findings Similar SU population
9	Gunarat nam 2011	End of life	Palliative care profession als	Focus groups Thematic and case study analysis	Narrative approaches can recognise and work with vulnerability and ambiguity to support holistic care. Cultural vulnerability	Strong Method Quotes	Medium Significant for methodology
10	Mantho rpe et al. 2010	Mental health	80 practitione	Interviews	Facets of MH important for BME; - Promote inclusion and activity - Linking expertise in aging and equality	Low	Medium

			rs SUs and carers		<ul style="list-style-type: none"> - Impact of stigma to be recognised - Responding to risk of isolation - Talking as important – staff confidence low - Localised training 	Limited method Doesn't address weaknesses	Some relevant outcomes
11	Manthorpe et al. 2009	Older people	1839 older people from 10 LAs	Public events Nominal group interviews Individual interviews Monitoring forms	Problems obtaining info about services Not just translation needed – appropriate and relevant content Differential experiences of interpreting services Participants had high satisfaction rates with GP but practitioners believe is poor as don't refer Responsiveness and acceptability of existing services as an issue Differential service user involvement	Strong Method Quotes Limitations	Medium Diverse SU group but relatable outcomes
12	Barn 2008	Mental health	10 Bangladeshi SWs	Semi-structured interviews	<ul style="list-style-type: none"> - MH concerns mostly identified from child protection referrals - Links to DV, language, gendered 'male' domains - fear of external agencies - stigma and lack of understanding – MH not seen as a legitimate illness, seen in physical terms - Concern re appropriateness and responsiveness of services - poor GP prescribing and referring - Communication and trust, cultural and religious understanding - Confidence building for white workers Challenge of 'male' spokesperson	Medium Quotes No ID of analysis method	High Similar SU group
13	Gunaratnam 2008	End of life	56 health and social care EOL workers	Qualitative focus group interviews	Discusses terminology Abstract systems like cultural competence and the desire for cultural knowledge can constrain the provision of care and shouldn't be prioritised over individualised support	Strong Quotes Method	Medium Theoretical relevance

					Threatens the nature of inter-relation between death and difference Lack of knowledge and passivity can enable receptivity to personalised needs and social exclusion		
14	Atkin 2007	Children and Families	Profs, parents, carers, children Mixed ethnic backgrounds	Focus groups for pracs Interviews for CandF	-Legitimacy of state intervention and the domain of the family is complex - importance of sensitivity to familial/kinship relationships in the context of caring (where intervention is seen as appropriate) - Reflexive practice in the application of policy into practice is necessary	Medium Method No themes	Medium Different SU group Same ME
15	Merrell et al. 2006	Carers	Bangladeshi carers	20 face to face focussed interviews	Barriers to accessing health and social care provision; -Information; lack of knowledge about services /roles -language barriers -Poor GP referrals -confidence, age and gender related to this -poor interpreting services -lack of cultural contextual understanding	Medium Method Quotes	High Similar SU group Similar ME group
16	Lawrence et al. 2006	Mental health	110 older adults mixed ethnic groups all with depression	In depth interviews	Social model closer to older peoples beliefs Language of depression varies by ethnic group White British and Black Caribbean = hopelessness/low mood South Asians = 'worry'	Strong Method	Low Different SU group Mixed ME groups Little relevant info
17	Hoong-Sin 2006	Older People	38 interviews 55+ south Asian	Mixed methods: Structured	White British respondents – high expectations of state support irrespective of expectations of family support Indian-Asians – high expectations of state only if high expectations of family	High Quotes Method	Medium Similar ME group Similar age group

			men/women	Questionnaire and qualitative interviews	A-I – low knowledge of health and social care services, and low utilisation, family as expected source of care, particularly for A-I women Male expectation of state, female expectation of family		
18	Mold et al. 2005	Dementia and residential care	Literature review	Systematic database searches	UK literature identifies; -lack of empirical evidence and statistics re: ME in care homes -barriers to care provision for ME older people -more tailored services and more existing services to participate and engage -loss of independence -recognition of cultural needs – failure to cater for food, religious practices, ME staff and interpreters -recommends training	Medium Method	Medium Similar ME group Similar age group
19	Alam et al. 2005	Visual impairment	80 Adults with visual impairments – mixed ethnicities	Focus group In-depth interviews Discussions with profs	-related everyday racism as connected to practitioner racism/assumptions -rehab services low priority compared to needs with health, social care and housing -translation of information not as useful as conversations to raise awareness of services -all ethnic groups thought lists of contacts were confusing	Medium Method No quotes	Medium Generalisable themes
20	Bettie et al. 2005	Dementia	Professionals and carers from 3 diverse LAs	61 interviews	-no specialist dementia services available in areas with low ME population -in 'black services' distrust of GP diagnoses and belief in racist system = mislabelling -service-led mentality apparent = unsuitable provisions -funding, especially transport as challenging – universal issue	Strong Quotes Method	Medium Different ME groups Different SU group Generalisable findings
21	Forbat 2004	Dementia and carers	14 south Asian and African	Interviews	-Treatment of carers and service users by LAs is fusion of abuse and institutional racism -Policy is institutionally racist (choice to care)	Strong Method	High

			Caribbean dementia sufferers/careers		-Participants link ethnicity to lack of appropriate services at institutional not individual practitioner level. -Assuming racism is connected to receipt of care is connected to co-constructed understanding in the interaction where this assumption was made Need to further explore meaning taken from interactions using narrative approaches	Quotes	Methodological and ME similarities
22	Livingston et al. 2002	Older people	1085 65+ Cypriot and African-Caribbeans	Interviews Structured assessment tools	15% of people unable to participate as no interpreter available -immigrants accessed primary and secondary health services at least at same level as white British population	Low No recognition of methodological limitations Stats only	Low Different ME group Different SU group
23	McGrother et al. 2002	Learning Disability	206 South Asian and 2334 White British adults	Census statistics and semi-structured interviews	-South Asian and white population have similar incidence of LD but with lower overall skills -SA have lower use of – psychiatry, residential and respite services -Same use of community services but higher unmet need especially from social work -culturally appropriate services and skill development in community care is needed	Medium No quotes	Medium Similar service user group
24	Burr 2002	Mental Health	29 mental health professionals	Focus groups with MH professionals	-stereotypes of western superiority and fixed and immutable construction of South Asian women as repressive, patriarchal and inferior = orientalism -stereotypes incorporated as fact = potential to misdirect diagnosis and misdirect treatment pathways	Strong Quotes Method	High Similar Su and ME group

				Interviews with GP and psychiatrist	-poor social conditions are seen as important to mental health		
25	Goldstein 2002	Care workers	28 Black social care workers	Not given but implies interviews	Employment practice of hiring ME workers to work with and promote equal rights for ME service users is contributing to high stress levels and negative working conditions -need skills based not race based ethos and challenge racism towards workers -ME workers wanted to help but added to stress	Medium/Low Quotes No clear method	Low Different focus

**A Research Project:
Pakistani Heritage Individuals' Access to Health and Social Care**

You have been given this leaflet because I am hoping you will participate in a research study I am carrying out.

The study looks at the services available from the NHS and Local Authority and I want to look more closely at whether services are used by people of Pakistani heritage. You don't have to have experience of any specific services, or even know that they exist to participate in the study.

If you agree to be a participant in the study, this means you agree for the researcher to speak to you, for up to an hour on one or two occasions, in a location of your choice. If you require an interpreter to translate your interview, this can be a person of your choosing or an independent person. The questions will ask about your experiences of health and social care, so the person you choose to translate should be someone you feel comfortable talking openly in front of. The interviews will be recorded but they will be anonymised and your personal information will never be shared with anyone else.

This study is being completed because it is important that everybody has the same opportunity to access services that will support them to live more independent lives. As a result of your participation changes could be made to the services to make them easier for you and other Pakistani individuals to use.

It is important that you do not feel pressured into agreeing to participate in the research project. Please feel free to discuss this information with your friends, family or carers before making a decision.

Thank you for your time,

Sarah Pollock - Principal Researcher

S.A.Pollock@salford.ac.uk

Appendix 3: Consent Form

Participant Identification Number:

CONSENT FORM

Participation in Preventative NHS and Social Care Services – The Relationship between
Available
Services and Minority Ethnic Groups

Name of Researcher: **Sarah Pollock**

Please initial box

1. I confirm that I have read and understand the information sheet dated XXXX for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

☐

3. I understand that any information given by me may be used anonymously in future reports, articles or presentations by the research team.

☐

4. I understand that my name will not appear in any reports, articles or presentations.

☐

5. I agree to take part in the above study.

☐

6. I understand that during the project my information will be recorded in both written and audio format and will be stored for a maximum of five years, to ensure the project has been completed.

☐

_____	_____	

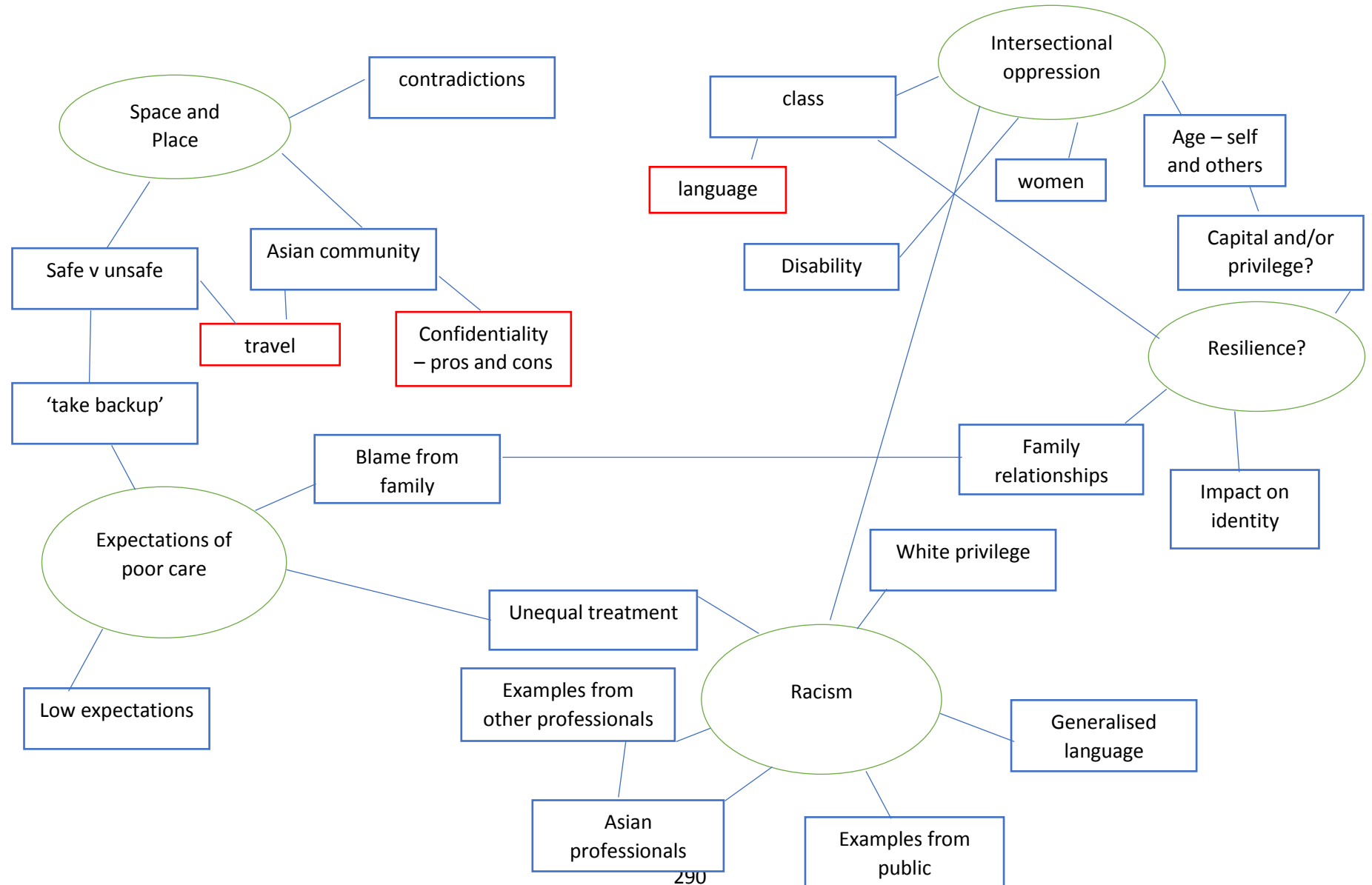
Name of Participant	Date	Signature
_____	_____	

Name of Interpreter	Date	Signature
_____	_____	

Researcher	Date	Signature

When completed, please return in the envelope provided (if applicable). One copy will be given to the participant and the original to be kept in the file of the research team at: Manchester Metropolitan University.

Appendix 4: Initial thematic map, demonstrating phase four of thematic analysis



Appendix 5: Final refined themes and subthemes

